STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION

REQUEST FOR PROPOSALS
FOR
PHARMACY BENEFITS MANAGEMENT
RFP # 31786-00143

RELEASE #3

RFP CONTENTS

APPENDICES:

- **7.1. Financial Analytic Model Description**
- **7.2. Medical Options Comparison for 2019**
- **7.3. TN Zip Code Counts**
- **7.4. Formulary Disruption Template**
- **7.5. SOT Summary by Plan Group**
- **7.6. SOT Summary by Plan**
- **7.7. GeoAccess Analysis Instructions**
- **7.8. Sample GeoNetworks Analysis**
- **7.9. Claims Data History (January 2017-May 2018)**
- **7.10. DSS File Format**
- **7.11. Benefits Administration 834 Guidance Manual**
- **7.12. Calendar Year 2019 Pharmacy Benefits**
- **7.13. RxClaims_Summary Information**
- **7.14. RxClaims 1 of 4**
- **7.15. RxClaims 2 of 4**
- **7.16. RxClaims 3 of 4**
- **7.17. RxClaims 4 of 4**
- **7.18. Quest Analytics Network Access Analysis Instructions**
- **7.19. Sample Quest Analytics Access Report**
- **7.20. Utilization Management List**
- **7.21. Cost Proposal – Brand Specialty Pricing Worksheet**

1. INTRODUCTION

The State of Tennessee, the State, Local Education, and Local Government Insurance Committees, hereinafter referred to as "the State," to define minimum contract requirements; solicit responses; detail response requirements; and, outline the State's process for evaluating responses and selecting a contractor to provide the needed goods or services.

Through this RFP, the State seeks to procure necessary goods or services at the most favorable, competitive prices and to give ALL qualified respondents, including those that are owned by minorities, women, service-disabled veterans, persons with disabilities and small business enterprises, an opportunity to do business with the state as contractors, subcontractors or suppliers.

1.1. Statement of Procurement Purpose

The State intends to secure a contract with a single Pharmacy Benefits Manager (PBM) for pharmacy benefit account management, network and Formulary management, utilization management, custom clinical programs as required, and an online Point-of-Sale (POS) pharmacy claims processing system. The PBM shall manage a broad national pharmacy network and a statewide any willing provider pharmacy network of retail, 90-Day-At-Retail, Mail Order Service and specialty pharmacies. The POS system shall include prospective/concurrent Drug Utilization Review (DUR), retrospective Drug Utilization Review (Retro-DUR), reporting capabilities, adjudication capabilities, and full pharmacy benefit Member services for retail, 90-day-at-retail, Mail Order Service and Specialty Pharmacy benefits for Members of the Plans (Plan). The Contractor shall perform all services described in the Scope of the *pro forma* contract (RFP Attachment 6.6) that are required in the scope of the contract and as listed in the milestones and deliverables in Section A.29.

1.1.1 Background and Context

Benefits Administration (BA) provides prescription drug benefits through a contract with CaremarksPCS Health, LLC that runs until December 31, 2019. Benefits for the contract under this RFP will go-live on January 1, 2020 and run through December 31, 2024, constituting a five (5) year PBM proposal requirement.

Prescription drug benefits for the Plan requested under this RFP, and as defined in the *pro forma* contract, (RFP Attachment 6.6), will be provided to three separate plans with coordinated benefit governing bodies charged with the responsibilities of providing benefits to the Plan. The State Insurance Committee, aka the State Plan, provides benefits to state and higher education employees, retirees and Consolidated Omnibus Budget Reconciliation Act (COBRA) participants and their dependents. The Local Education Insurance Committee, aka the Local Education Plan provides benefits to 132 local education agencies (public school systems) and educational co-ops. The Local Government Insurance Committee, aka the Local Government Plan, provides benefits to 350 local government and quasi-governmental entities in Tennessee. See the 2016 Annual Program and Financial Report, State Group Insurance Program, for a description of program and plan information. The report can be accessed at https://www.tn.gov/finance/fa-benefits.html. Click on the *Publications and Forms* button, then click on *Publications then click on Annual Reports*.

The State Plan currently provides self-funded medical coverage to approximately 144,700 total lives (132,688 State and higher education employees, 12,015 pre-65 retirees and their eligible dependents) through three health plan options: a Standard PPO, Premier PPO and a Consumer Driven Health Plan (CDHP) paired with a Health Savings Account (HSA). The State, as the employer, contributes monthly to premiums for enrollment in all plan options. Approximately $252.2 million in pharmacy claims (net plan costs) were paid under these plan options during calendar year 2017.

As a supplement to the medical plan, which includes pharmacy, the State offers a carved out employee assistance program (EAP) and behavioral health benefit. An employee wellness

program is also available to all plan Members. Voluntary benefits include vision, prepaid dental, preferred dental organization, and short and long term disability.

The Local Education Plan is a financially separate, self-funded program, which offers similar health benefits (Standard PPO, Premier PPO, Limited PPO, and Local CDHP/HSA) as the State Plan, but to 132 Local Education Agency employees and retirees. Enrollment, as of late 2017, was approximately 103,416 employees and 6,439 retirees and their dependents for a total of approximately 109,855 covered lives. The majority of employees are teachers; the balance is comprised of administrators, cafeteria workers, maintenance and other support personnel. Approximately $158 million in pharmacy claims (net plan costs) were paid under these plan options during calendar year 2017. In addition to health insurance coverage consisting of medical, pharmacy, behavioral health, and EAP, Local Education Agencies are offered the same vision and dental plans available to Members.

The Local Government Plan is also a financially separate, self-funded program, available to employees of 350 local governments or quasi-governmental entities in Tennessee who elect health insurance coverage through this plan. The health benefits (Standard PPO, Premier PPO, Limited PPO and Local CDHP/HSA) and their administrators are identical to those under the Local Education Plan. In 2017 there were approximately 23,004 employees 307 retirees and their dependents enrolled in the plan options for a total of approximately 23,311 covered lives. Approximately $36.9 million in pharmacy claims (net plan costs) were paid under these plan options during calendar year 2017. In addition to health insurance coverage, consisting of medical, pharmacy, behavioral health, and EAP, Local Government Agencies are offered the same vision and dental plans available to Members.

The pharmacy benefits include a value-based benefit design for diabetic drugs (oral, insulin, and other non-insulin injectables) and supplies (needles, test strips, and lancets *only*), statins, anti-hypertensives, as well as medications used to treat depression, coronary artery disease (CAD), congestive heart failure (CHF), and asthma/ chronic obstructive pulmonary disease (COPD). A 90-day supply of these medications and supplies are available for a lower Copayment (or Coinsurance, if enrolled in the CHPA/HSA or Local CDHP/HSA options) **if obtained from an in-network Retail 90 pharmacy or through Mail Order Service**. This benefit is administered by utilizing various generic product identifiers (GPIs) to determine which products and medications are part of the covered benefits. In addition, these medications bypass the deductible for those enrolled in a CDHP. The State of Tennessee uses CVS Caremark's advanced control specialty formulary (ACSF) which requires Members to use a preferred product in numerous specialty classes. The ACSF can be viewed by visiting https://www.caremark.com/portal/asset/Advanced_Control_Specialty_Preferred_Drug_List.pdf. The State requires that any and all specialty pharmacies that meet certain criteria contained in the contract and who agree to the pricing terms offered by the Contractor be allowed to participate in the Contractor's Specialty Network. Also regarding Step Therapy or other similar drug edits, the State implemented a dispense as written policy on 1/1/2013 whereby if a Generic Drug is available and a Member's doctor indicates "may substitute" on the prescription but the Member requests the brand name drug from the pharmacy, the Member must pay the difference between the brand name drug and the Generic Drug plus the brand Copay/Coinsurance applicable to his/her health plan option (Premier PPO, Standard PPO, Limited PPO, CDHP/HSA, or Local CDHP/HSA). More information about the medical options provided to Members is shown in Appendix 7.2. Break down summaries of insurance coverage by plan and plan group are shown in Appendices 7.5 and 7.6.

Plan pharmacy claims data (de-identified, basic cost and use data only) for January 2017 – May 2018 is included as Appendix 7.9. Respondents must use the Medi-Span post-settlement Average Wholesale Price (AWP) methodology for all cost proposal calculations submitted in the Cost Proposal for evaluation.

See Appendix 7.12 for a grid showing the Copayments for plan year 2019.

A full year of claims data representing 4/1/2017 through 3/31/2018 by individual claim line item is provided in Appendices 7.14. through 7.17. Appendix 7.13 provides background information on data sets and how potential respondents may merge them to respond to this RFP.

1.1.2 The maximum liability for the resulting contract will be determined through the best evaluated cost proposal and estimated cost associated with this service. The maximum liability will exceed one dollar ($1.00).

1.2. Scope of Service, Contract Period, & Required Terms and Conditions

The RFP Attachment 6.6., *Pro Forma* Contract details the State's required:

- Scope of Services and Deliverables (Section A);
- Contract Period (Section B);
- Payment Terms (Section C);
- Standard Terms and Conditions (Section D); and,
- Special Terms and Conditions (Section E).

The *pro forma* contract substantially represents the contract document that the successful Respondent must sign.

1.3. Nondiscrimination

No person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of a Contract pursuant to this RFP or in the employment practices of the Contractor on the grounds of handicap or disability, age, race, creed, color, religion, sex, national origin, or any other classification protected by federal, Tennessee state constitutional, or statutory law. The Contractor pursuant to this RFP shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

1.4. RFP Communications

1.4.1. The State has assigned the following RFP identification number that must be referenced in all communications regarding this RFP:

RFP # 31786-00143

1.4.2. **Unauthorized contact about this RFP with employees or officials of the State of Tennessee except as detailed below may result in disqualification from consideration under this procurement process.**

1.4.2.1. Prospective Respondents must direct communications concerning this RFP to the following person designated as the Solicitation Coordinator:

Seannalyn Brandmeir, Procurement and Contracting Manager
Tennessee Department of Finance & Administration
Division of Benefits Administration
William R. Snodgrass Tennessee Tower
312 Rosa L. Parks Avenue, Suite 1900
Nashville, Tennessee 37243
seannalyn.brandmeir@tn.gov
Telephone: 615.532.4598
Fax: 615.253.8556

1.4.2.2. Notwithstanding the foregoing, Prospective Respondents may alternatively contact:

a. staff of the Governor's Office of Diversity Business Enterprise for assistance available to minority-owned, woman-owned, service-disabled veteran-owned, businesses owned by persons with disabilities, and small businesses as well as general, public information relating to this RFP (visit https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/governor-s-office-of-diversity-business-enterprise--godbe--/godbe-general-contacts.html for contact information); and

b. the following individual designated by the State to coordinate compliance with the nondiscrimination requirements of the State of Tennessee, Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, and associated federal regulations:

David Sledge
Title VI Coordinator
Tennessee Department of Finance & Administration
Office of Human Resources
312 Rosa L. Parks Avenue, Suite 2100
Nashville, Tennessee 37243
Phone: 615.532.4595
Fax: 615.741.3470
David.Sledge@tn.gov

1.4.3. Only the State's official, written responses and communications with Respondents are binding with regard to this RFP. Oral communications between a State official and one or more Respondents are unofficial and non-binding.

1.4.4. Potential Respondents must ensure that the State receives all written questions and comments, including questions and requests for clarification, no later than the Written Questions & Comments Deadline detailed in the RFP Section 2, Schedule of Events.

1.4.5. Respondents must assume the risk of the method of dispatching any communication or response to the State. The State assumes no responsibility for delays or delivery failures resulting from the Respondent's method of dispatch. Actual or digital "postmarking" of a communication or response to the State by a specified deadline is not a substitute for the State's actual receipt of a communication or response.

1.4.6. The State will convey all official responses and communications related to this RFP to the prospective Respondents from whom the State has received a Notice of Intent to Respond (refer to RFP Section 1.8.).

1.4.7. The State reserves the right to determine, at its sole discretion, the method of conveying official, written responses and communications related to this RFP. Such written communications may be transmitted by mail, hand-delivery, facsimile, electronic mail, Internet posting, or any other means deemed reasonable by the State. For internet posting, please refer to the following website: https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/supplier-information-/request-for-proposals--rfp--opportunities.html.

1.4.8. The State reserves the right to determine, at its sole discretion, the appropriateness and adequacy of responses to written comments, questions, and requests related to this RFP. The State's official, written responses will constitute an amendment of this RFP.

1.4.9. Any data or factual information provided by the State (in this RFP, an RFP amendment or any other communication relating to this RFP) is for informational purposes only. The State will make reasonable efforts to ensure the accuracy of such data or information, however it is the Respondent's obligation to independently verify any data or information provided by the State.

The State expressly disclaims the accuracy or adequacy of any information or data that it provides to prospective Respondents.

1.5. Assistance to Respondents With a Handicap or Disability

Prospective Respondents with a handicap or disability may receive accommodation relating to the communication of this RFP and participating in the RFP process. Prospective Respondents may contact the Solicitation Coordinator to request such reasonable accommodation no later than the Disability Accommodation Request Deadline detailed in the RFP Section 2, Schedule of Events.

1.6. Respondent Required Review & Waiver of Objections

1.6.1. Each prospective Respondent must carefully review this RFP, including but not limited to, attachments, the RFP Attachment 6.6., *Pro Forma* Contract, and any amendments, for questions, comments, defects, objections, or any other matter requiring clarification or correction (collectively called "questions and comments").

1.6.2. Any prospective Respondent having questions and comments concerning this RFP must provide them in writing to the State no later than the Written Questions & Comments Deadline detailed in the RFP Section 2, Schedule of Events.

1.6.3. Protests based on any objection to the RFP shall be considered waived and invalid if the objection has not been brought to the attention of the State, in writing, by the Written Questions & Comments Deadline.

1.7. Pre-Response Conference

A Pre-response Conference will be held at the time and date detailed in the RFP Section 2, Schedule of Events. Pre-response Conference attendance is not mandatory, and prospective Respondents may be limited to a maximum number of attendees depending upon overall attendance and space limitations.

The conference will be held at:

Conference Center North
William R. Snodgrass Tennessee Tower
3rd Floor – **Conference Room N**
312 Rosa L. Parks Avenue
Nashville, Tennessee 37243
Telephone: 615.532.4598

Please enter the building on the Seventh Avenue side (adjacent to War Memorial Plaza). Check in at the security desk on the Third Floor. Arrive early due to heightened security. You must show a government issued photo ID. The conference room is on the left hand side through a set of double glass doors.

Webex information:
Webex meeting *(active link to web address)*
Meeting number (access code): 315 817 319
Meeting password: rxHem9D8

The purpose of the conference is to discuss the RFP scope of goods or services. The State will entertain questions, however prospective Respondents must understand that the State's oral response to any question at the Pre-response Conference shall be unofficial and non-binding. Prospective Respondents must submit all questions, comments, or other concerns regarding the RFP in writing prior to the Written Questions & Comments Deadline date detailed in the RFP Section 2, Schedule of Events. The State will send the official response to these questions and comments to prospective Respondents from whom the State has received a Notice of Intent to respond as indicated in RFP Section 1.4.6. and on the date detailed in the RFP Section 2, Schedule of Events.

Notice of Intent to Respond

Before the Notice of Intent to Respond Deadline detailed in the RFP Section 2, Schedule of Events, prospective Respondents should submit to the Solicitation Coordinator a Notice of Intent to Respond (in the form of a simple e-mail or other written communication). Such notice should include the following information:

- the business or individual's name (as appropriate);
- a contact person's name and title; and
- the contact person's mailing address, telephone number, facsimile number, and e-mail address.

A Notice of Intent to Respond creates no obligation and is not a prerequisite for submitting a response, however, it is necessary to ensure receipt of any RFP amendments or other notices and communications relating to this RFP.

1.9. **Response Deadline**

A Respondent must ensure that the State receives a response no later than the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events. The State will not accept late responses, and a Respondent's failure to submit a response before the deadline will result in disqualification of the response. It is the responsibility of the Respondent to ascertain any additional security requirements with respect to packaging and delivery to the State of Tennessee. Respondents should be mindful of any potential delays due to security screening procedures, weather, or other filing delays whether foreseeable or unforeseeable.

2. RFP SCHEDULE OF EVENTS

2.1. The following RFP Schedule of Events represents the State's best estimate for this RFP.

EVENT	TIME (central time zone)	DATE
1. RFP Issued		November 15, 2018
2. Disability Accommodation Request Deadline	2:00 p.m.	November 20, 2018
3. Pre-response Conference	10:30 a.m.	November 26, 2018
4. Notice of Intent to Respond Deadline	2:00 p.m.	November 27, 2018
5. Written "Questions & Comments" Deadline	2:00 p.m.	December 3, 2018
6. State Response to Written "Questions & Comments"		January 18, 2019
7. Response Deadline	2:00 p.m.	February 21, 2019
8. State Completion of Technical Response Evaluations		March 18, 2019
9. State Opening & Scoring of Cost Proposals	2:00 p.m.	March 19, 2019
10. State Notice of Intent to Award Released		Day of Insurance Committee Award of Contract
11. RFP Files Opened for Public Inspection	8:30 a.m.	1 Day after Insurance Committee Award of Contract
12. End of Open File Period		7 CALENDAR DAYS LATER
13. State sends contract to Contractor for signature		1 BUSINESS DAY LATER
14. Contractor Signature Deadline	2:00 p.m.	1 – 5 BUSINESS DAYS LATER

2.2. **The State reserves the right, at its sole discretion, to adjust the RFP Schedule of Events as it deems necessary.** Any adjustment of the Schedule of Events shall constitute an RFP amendment, and the State will communicate such to potential Respondents from whom the State has received a Notice of Intent to Respond (refer to section 1.8.).

3. PROPOSAL REQUIREMENTS

3.1. Response Form

A response to this RFP must consist of two parts, a Technical Response and a Cost Proposal.

3.1.1. **Technical Response**. RFP Attachment 6.2., Technical Response & Evaluation Guide provides the specific requirements for submitting a response. This guide includes mandatory requirement items, general qualifications and experience items, and technical qualifications, experience, and approach items all of which must be addressed with a written response and, in some instances, additional documentation.

NOTICE: A technical response must not include any pricing or cost information. If any pricing or cost information amounts of any type (even pricing relating to other projects) is included in any part of the technical response, the state may deem the response to be non-responsive and reject it.

3.1.1.1. A Respondent must use the RFP Attachment 6.2., Technical Response & Evaluation Guide to organize, reference, and draft the Technical Response by duplicating the attachment, adding appropriate page numbers as required, and using the guide as a table of contents covering the Technical Response.

3.1.1.2. A Technical Response should be economically prepared, with emphasis on completeness and clarity, and should NOT exceed 175 pages in length (maps, graphs, charts, as noted and included as an appendix will not count against this page limit). A response, as well as any reference material presented, must be written in English and must be written on standard 8 ½" x 11" pages (although oversize exhibits are permissible) and all text must be at least a 12 point font. All response pages must be numbered.

3.1.1.3. All information and documentation included in a Technical Response should correspond to or address a specific requirement detailed in the RFP Attachment 6.2., Technical Response & Evaluation Guide. All information must be incorporated into a response to a specific requirement and clearly referenced. Any information not meeting these criteria will be deemed extraneous and will not contribute to evaluations.

3.1.1.4. The State may determine a response to be non-responsive and reject it if:

a. the Respondent fails to organize and properly reference the Technical Response as required by this RFP and the RFP Attachment 6.2., Technical Response & Evaluation Guide; or

b. the Technical Response document does not appropriately respond to, address, or meet all of the requirements and response items detailed in the RFP Attachment 6.2., Technical Response & Evaluation Guide.

3.1.2. **Cost Proposal**. A Cost Proposal must be recorded on an exact duplicate of the RFP Attachment 6.3., Cost Proposal & Scoring Guide.

NOTICE: If a Respondent fails to submit a cost proposal exactly as required, the State may deem the response to be non-responsive and reject it.

3.1.2.1. A Respondent must only record the proposed cost exactly as required by the RFP Attachment 6.3., Cost Proposal & Scoring Guide and must NOT record any other rates, amounts, or information.

3.1.2.2. The proposed cost shall incorporate ALL costs for services under the contract for the total contract period, including any renewals or extensions.

3.1.2.3. A Respondent must sign and date the Cost Proposal.

3.1.2.4. A Respondent must submit the Cost Proposal to the State in a sealed package separate from the Technical Response (as detailed in RFP Sections 3.2.3., *et seq.*).

3.2. Response Delivery

3.2.1. A Respondent must ensure that both the original Technical Response and Cost Proposal documents meet all form and content requirements, including all required signatures, as detailed within this RFP, as may be amended.

3.2.2. A Respondent must submit original Technical Response and Cost Proposal documents and copies as specified below.

3.2.2.1. One (1) original Technical Proposal paper document labeled:

"RFP # 31786-00143 TECHNICAL PROPOSAL ORIGINAL"

and seven (7) digital copies of the Technical Response each in the form of one (1) digital document in "PDF" format properly recorded on its own otherwise blank, USB flash drive labeled:

"RFP # 31786-00143 TECHNICAL RESPONSE COPY"

The digital copies should not include copies of sealed customer references, however any other discrepancy between the paper Technical Response document and any digital copies may result in the State rejecting the proposal as non-responsive.

3.2.2.2. One (1) original Cost Proposal paper document labeled:

"RFP # 31786-00143 COST PROPOSAL ORIGINAL"

and one (1) copy in the form of a digital document in "XLS" format properly recorded on separate, blank, USB flash drive labeled:

"RFP # 31786-00143 COST PROPOSAL COPY"

In the event of a discrepancy between the original Cost Proposal document and the digital copy, the original, signed document will take precedence.

3.2.3. A Respondent must separate, seal, package, and label the documents and copies for delivery as follows:

3.2.3.1. The Technical Response original document and digital copies must be placed in a sealed package that is clearly labeled:

"DO NOT OPEN… RFP # 31786-00143 TECHNICAL RESPONSE FROM [RESPONDENT LEGAL ENTITY NAME]"

3.2.3.2. The Cost Proposal original document and digital copy must be placed in a separate, sealed package that is clearly labeled:

"DO NOT OPEN… RFP # 31786-00143 COST PROPOSAL FROM [RESPONDENT LEGAL ENTITY NAME]"

3.2.3.3. The separately, sealed Technical Response and Cost Proposal components may be enclosed in a larger package for mailing or delivery, provided that the outermost package is clearly labeled:

"RFP # 31786-00143 SEALED TECHNICAL RESPONSE & SEALED COST PROPOSAL FROM [RESPONDENT LEGAL ENTITY NAME]"

3.2.4. A Respondent must ensure that the State receives a response no later than the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events at the following address:

Seannalyn Brandmeir, Procurement and Contracting Manager
Tennessee Department of Finance & Administration
Benefits Administration Division
William R. Snodgrass Tennessee Tower
312 Rosa L. Parks Avenue, Suite 1900
Nashville, Tennessee 37243

3.3. **Response & Respondent Prohibitions**

3.3.1. A response must not include alternate contract terms and conditions. If a response contains such terms and conditions, the State, at its sole discretion, may determine the response to be a non-responsive counteroffer and reject it.

3.3.2. A response must not restrict the rights of the State or otherwise qualify either the offer to deliver goods or provide services as required by this RFP or the Cost Proposal. If a response restricts the rights of the State or otherwise qualifies either the offer to deliver goods or provide services as required by this RFP or the Cost Proposal, the State, at its sole discretion, may determine the response to be a non-responsive counteroffer and reject it.

3.3.3. A response must not propose alternative goods or services (*i.e.*, offer services different from those requested and required by this RFP) unless expressly requested in this RFP. The State may consider a response of alternative goods or services to be non-responsive and reject it.

3.3.4. A Cost Proposal must be prepared and arrived at independently and must not involve any collusion between Respondents. The State will reject any Cost Proposal that involves collusion, consultation, communication, or agreement between Respondents. Regardless of the time of detection, the State will consider any such actions to be grounds for response rejection or contract termination.

3.3.5. A Respondent must not provide, for consideration in this RFP process or subsequent contract negotiations, any information that the Respondent knew or should have known was materially incorrect. If the State determines that a Respondent has provided such incorrect information, the State will deem the Response non-responsive and reject it.

3.3.6. A Respondent must not submit more than one Technical Response and one Cost Proposal in response to this RFP, except as expressly requested by the State in this RFP. If a Respondent submits more than one Technical Response or more than one Cost Proposal, the State will deem all of the responses non-responsive and reject them.

3.3.7. A Respondent must not submit a response as a prime contractor while also permitting one or more other Respondents to offer the Respondent as a subcontractor in their own responses. Such may result in the disqualification of all Respondents knowingly involved. This restriction does not, however, prohibit different Respondents from offering the same subcontractor as a part

of their responses (provided that the subcontractor does not also submit a response as a prime contractor).

3.3.8. The State shall not consider a response from an individual who is, or within the past six (6) months has been, a State employee. For purposes of this RFP:

3.3.8.1. An individual shall be deemed a State employee until such time as all compensation for salary, termination pay, and annual leave has been paid;

3.3.8.2. A contract with or a response from a company, corporation, or any other contracting entity in which a controlling interest is held by any State employee shall be considered to be a contract with or proposal from the employee; and

3.3.8.3. A contract with or a response from a company, corporation, or any other contracting entity that employs an individual who is, or within the past six (6) months has been, a State employee shall not be considered a contract with or a proposal from the employee and shall not constitute a prohibited conflict of interest.

3.4. Response Errors & Revisions

A Respondent is responsible for any and all response errors or omissions. A Respondent will not be allowed to alter or revise response documents after the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events unless such is formally requested, in writing, by the State.

3.5. Response Withdrawal

A Respondent may withdraw a submitted response at any time before the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events by submitting a written request signed by an authorized Respondent representative. After withdrawing a response, a Respondent may submit another response at any time before the Response Deadline. After the Response Deadline, a Respondent may only withdraw all or a portion of a response where the enforcement of the response would impose an unconscionable hardship on the Respondent.

3.6. Additional Services

If a response offers goods or services in addition to those required by and described in this RFP, the State, at its sole discretion, may add such services to the contract awarded as a result of this RFP. Notwithstanding the foregoing, a Respondent must not propose any additional cost amounts or rates for additional goods or services. Regardless of any additional services offered in a response, the Respondent's Cost Proposal must only record the proposed cost as required in this RFP and must not record any other rates, amounts, or information.

NOTICE: If a Respondent fails to submit a Cost Proposal exactly as required, the State may deem the response non-responsive and reject it.

3.7. Response Preparation Costs

The State will not pay any costs associated with the preparation, submittal, or presentation of any response.

4. GENERAL CONTRACTING INFORMATION & REQUIREMENTS

4.1. RFP Amendment

The State at its sole discretion may amend this RFP, in writing, at any time prior to contract award. However, prior to any such amendment, the State will consider whether it would negatively impact the ability of potential Respondents to meet the response deadline and revise the RFP Schedule of Events if deemed appropriate. If an RFP amendment is issued, the State will convey it to potential Respondents who submitted a Notice of Intent to Respond (refer to RFP Section 1.8.). A response must address the final RFP (including its attachments) as amended.

4.2. RFP Cancellation

The State reserves the right, at its sole discretion, to cancel the RFP or to cancel and reissue this RFP in accordance with applicable laws and regulations.

4.3. State Right of Rejection

4.3.1. Subject to applicable laws and regulations, the State reserves the right to reject, at its sole discretion, any and all responses.

4.3.2. The State may deem as non-responsive and reject any response that does not comply with all terms, conditions, and performance requirements of this RFP. Notwithstanding the foregoing, the State reserves the right to waive, at its sole discretion, minor variances from full compliance with this RFP. If the State waives variances in a response, such waiver shall not modify the RFP requirements or excuse the Respondent from full compliance, and the State may hold any resulting Contractor to strict compliance with this RFP.

4.4. Assignment & Subcontracting

4.4.1. The Contractor may not subcontract, transfer, or assign any portion of the Contract awarded as a result of this RFP without prior approval of the State. The State reserves the right to refuse approval, at its sole discretion, of any subcontract, transfer, or assignment.

4.4.2. If a Respondent intends to use subcontractors, the response to this RFP must specifically identify the scope and portions of the work each subcontractor will perform (refer to RFP Attachment 6.2., Section B, General Qualifications & Experience Item B.14.).

4.4.3. Subcontractors identified within a response to this RFP will be deemed as approved by the State unless the State expressly disapproves one or more of the proposed subcontractors prior to signing the Contract.

4.4.4. After contract award, a Contractor may only substitute an approved subcontractor at the discretion of the State and with the State's prior, written approval.

4.4.5. Notwithstanding any State approval relating to subcontracts, the Respondent who is awarded a contract pursuant to this RFP will be the prime contractor and will be responsible for all work under the Contract.

4.5. Right to Refuse Personnel or Subcontractors

The State reserves the right to refuse, at its sole discretion and notwithstanding any prior approval, any personnel of the prime contractor or a subcontractor providing goods or services in the performance of a contract resulting from this RFP. The State will document in writing the reason(s) for any rejection of personnel.

4.6. **Insurance**

The State will require the awarded Contractor to provide a Certificate of Insurance issued by an insurance company licensed or authorized to provide insurance in the State of Tennessee. Each Certificate of Insurance shall indicate current insurance coverages meeting minimum requirements as may be specified by this RFP. A failure to provide a current, Certificate of Insurance will be considered a material breach and grounds for contract termination.

4.7. **Professional Licensure and Department of Revenue Registration**

4.7.1. All persons, agencies, firms, or other entities that provide legal or financial opinions, which a Respondent provides for consideration and evaluation by the State as a part of a response to this RFP, shall be properly licensed to render such opinions.

4.7.2. Before the Contract resulting from this RFP is signed, the apparent successful Respondent (and Respondent employees and subcontractors, as applicable) must hold all necessary or appropriate business or professional licenses to provide the goods or services as required by the contract. The State may require any Respondent to submit evidence of proper licensure.

4.7.3. Before the Contract resulting from this RFP is signed, the apparent successful Respondent must be registered with the Tennessee Department of Revenue for the collection of Tennessee sales and use tax. The State shall not award a contract unless the Respondent provides proof of such registration or provides documentation from the Department of Revenue that the Contractor is exempt from this registration requirement. The foregoing is a mandatory requirement of an award of a contract pursuant to this solicitation. For purposes of this registration requirement, the Department of Revenue may be contacted at: TN.Revenue@tn.gov.

4.8. **Disclosure of Response Contents**

4.8.1. All materials submitted to the State in response to this RFP shall become the property of the State of Tennessee. Selection or rejection of a response does not affect this right. By submitting a response, a Respondent acknowledges and accepts that the full response contents and associated documents will become open to public inspection in accordance with the laws of the State of Tennessee.

4.8.2. The State will hold all response information, including both technical and cost information, in confidence during the evaluation process.

4.8.3. Upon completion of response evaluations, indicated by public release of a Notice of Intent to Award, the responses and associated materials will be open for review by the public in accordance with Tenn. Code Ann. § 10-7-504(a)(7).

4.9. **Contract Approval and Contract Payments**

4.9.1. After contract award, the Contractor who is awarded the contract must submit appropriate documentation with the Department of Finance and Administration, Division of Accounts.

4.9.2. This RFP and its contractor selection processes do not obligate the State and do not create rights, interests, or claims of entitlement in either the Respondent with the apparent best-evaluated response or any other Respondent. State obligations pursuant to a contract award shall commence only after the Contract is signed by the State agency head and the Contractor and after the Contract is approved by all other state officials as required by applicable laws and regulations.

4.9.3. No payment will be obligated or made until the relevant Contract is approved as required by applicable statutes and rules of the State of Tennessee.

4.9.3.1. The State shall not be liable for payment of any type associated with the Contract resulting from this RFP (or any amendment thereof) or responsible for any goods delivered or services rendered by the Contractor, even goods delivered or services rendered in good faith and even if the Contractor is orally directed to proceed with the delivery of goods or the rendering of services, if it occurs before the Contract Effective Date or after the Contract Term.

4.9.3.2. All payments relating to this procurement will be made in accordance with the Payment Terms and Conditions of the Contract resulting from this RFP (refer to RFP Attachment 6.6., *Pro Forma* Contract, Section C).

4.9.3.3. If any provision of the Contract provides direct funding or reimbursement for the competitive purchase of goods or services as a component of contract performance or otherwise provides for the reimbursement of specified, actual costs, the State will employ all reasonable means and will require all such documentation that it deems necessary to ensure that such purchases were competitive and costs were reasonable, necessary, and actual. The Contractor shall provide reasonable assistance and access related to such review. Further, the State shall not remit, as funding or reimbursement pursuant to such provisions, any amounts that it determines do not represent reasonable, necessary, and actual costs.

4.10. **Contractor Performance**

The Contractor who is awarded a contract will be responsible for the delivery of all acceptable goods or the satisfactory completion of all services set out in this RFP (including attachments) as may be amended. All goods or services are subject to inspection and evaluation by the State. The State will employ all reasonable means to ensure that goods delivered or services rendered are in compliance with the Contract, and the Contractor must cooperate with such efforts.

4.11. **Contract Amendment**

After Contract award, the State may request the Contractor to deliver additional goods or perform additional services within the general scope of the Contract and this RFP, but beyond the specified Scope, and for which the Contractor may be compensated. In such instances, the State will provide the Contractor a written description of the additional goods or services. The Contractor must respond to the State with a time schedule for delivering the additional goods or accomplishing the additional services based on the compensable units included in the Contractor's response to this RFP. If the State and the Contractor reach an agreement regarding the goods or services and associated compensation, such agreement must be effected by means of a contract amendment. Further, any such amendment requiring additional goods or services must be signed by both the State agency head and the Contractor and must be approved by other state officials as required by applicable statutes, rules, policies and procedures of the State of Tennessee. The Contractor must not provide additional goods or render additional services until the State has issued a written contract amendment with all required approvals.

4.12. **Severability**

If any provision of this RFP is declared by a court to be illegal or in conflict with any law, said decision will not affect the validity of the remaining RFP terms and provisions, and the rights and obligations of the State and Respondents will be construed and enforced as if the RFP did not contain the particular provision held to be invalid.

4.13. **Next Ranked Respondent**

The State reserves the right to initiate negotiations with the next ranked Respondent should the State cease doing business with any Respondent selected via this RFP process.

5. PROPOSAL EVALUATION & CONTRACT AWARD

5.1. Evaluation Categories & Maximum Points

The State will consider qualifications, experience, technical approach, and cost in the evaluation of responses and award points in each of the categories detailed below (up to the maximum evaluation points indicated) to each response deemed by the State to be responsive.

EVALUATION CATEGORY	MAXIMUM POINTS POSSIBLE
General Qualifications & Experience (refer to RFP Attachment 6.2., Section B)	**15**
Technical Qualifications, Experience & Approach (refer to RFP Attachment 6.2., Section C)	**40**
Cost Proposal (refer to RFP Attachment 6.3.)	**45**

5.2. Evaluation Process

The evaluation process is designed to award the contract resulting from this RFP not necessarily to the Respondent offering the lowest cost, but rather to the Respondent deemed by the State to be responsive and responsible who offers the best combination of attributes based upon the evaluation criteria. ("Responsive Respondent" is defined as a Respondent that has submitted a response that conforms in all material respects to the RFP. "Responsible Respondent" is defined as a Respondent that has the capacity in all respects to perform fully the contract requirements, and the integrity and reliability which will assure good faith performance.)

5.2.1. **Technical Response Evaluation.** The Solicitation Coordinator and the Proposal Evaluation Team (consisting of three (3) or more State employees) will use the RFP Attachment 6.2., Technical Response & Evaluation Guide to manage the Technical Response Evaluation and maintain evaluation records.

5.2.1.1. The State reserves the right, at its sole discretion, to request Respondent clarification of a Technical Response or to conduct clarification discussions with any or all Respondents. Any such clarification or discussion will be limited to specific sections of the response identified by the State. The subject Respondent must put any resulting clarification in writing as may be required and in accordance with any deadline imposed by the State.

5.2.1.2. The Solicitation Coordinator will review each Technical Response to determine compliance with RFP Attachment 6.2., Technical Response & Evaluation Guide, Section A— Mandatory Requirements. If the Solicitation Coordinator determines that a response failed to meet one or more of the mandatory requirements, the Proposal Evaluation Team will review the response and document the team's determination of whether:

a. the response adequately meets RFP requirements for further evaluation;

b. the State will request clarifications or corrections for consideration prior to further evaluation; or,

c. the State will determine the response to be non-responsive to the RFP and reject it.

5.2.1.3. Proposal Evaluation Team members will independently evaluate each Technical Response (that is responsive to the RFP) against the evaluation criteria in this RFP,

and will score each in accordance with the RFP Attachment 6.2., Technical Response & Evaluation Guide.

5.2.1.4. For each response evaluated, the Solicitation Coordinator will calculate the average of the Proposal Evaluation Team member scores for RFP Attachment 6.2., Technical Response & Evaluation Guide, and record each average as the response score for the respective Technical Response section.

5.2.1.5. Before Cost Proposals are opened, the Proposal Evaluation Team will review the Technical Response Evaluation record and any other available information pertinent to whether or not each Respondent is responsive and responsible. If the Proposal Evaluation Team identifies any Respondent that does not meet the responsive and responsible thresholds such that the team would not recommend the Respondent for Cost Proposal Evaluation and potential contract award, the team members will fully document the determination.

5.2.2. **Cost Proposal Evaluation.**

The Solicitation Coordinator will open for evaluation the Cost Proposal of each Respondent deemed by the State to be responsible for an initial check for completion of the cost proposals according to the directions contained in RFP Attachment 6.3. Cost Proposal & Scoring Guide.

This information for each responsible Respondent will be forwarded to an independent actuarial firm under contract with the Department of Finance & Administration, Division of Benefits Administration. The actuarial firm will also check for the completion of the cost proposals according to the directions contained in RFP Attachment 6.3. Cost Proposal & Scoring Guide. If any questions surface regarding the completion of the forms, the firm is instructed to contact the Solicitation Coordinator with the concern and the Solicitation Coordinator will take appropriate steps to determine the Proposal's responsiveness. The results from the actuarial analysis will be provided to the Solicitation Coordinator. The Solicitation Coordinator will calculate and record each Cost Proposal score in accordance with the RFP Attachment 6.3. Cost Proposal & Scoring Guide.

Please note: Tenn. Code Ann. § 10-7-504(n)(1)(A) provides that the following documents submitted to the state in response to a request for proposal or other procurement method shall remain confidential after completion of the evaluation period:

A. Discount, Rebate, pricing or other financial arrangements at the individual drug level between pharmaceutical manufacturers, pharmaceutical wholesalers/distributors, and pharmacy benefits managers, as defined in Tenn. Code Ann. § 56-7-3102 that a Respondent:
    i. Submits to the state in response to a request for proposals or other procurement methods for pharmacy-related benefits or services;
    ii. Includes in its cost or price proposal, or provides to the state after the notice of intended award of the contract is issued, where the Respondent is the apparent contract awardee; and
    iii. Explicitly marks as confidential and proprietary; and

B. Discount, Rebate, pricing or other financial arrangements at the individual provider level between health care providers and health insurance entities, as defined in Tenn. Code Ann.56-7-109, insurers, insurance arrangements and third party administrators that a Respondent:
    i. Submits to the state in response to a request for proposals or other procurement method after the notice of intended award of the contract is issued, where the Respondent is the apparent contact awardee, in response to a request by the state for additional information, and
    ii. Explicitly marks as confidential and proprietary

As such, the State commits to maintain strict confidentiality and oversight over any proprietary Discount rates, AWP amounts or percentage, to the extent permitted by the statute.

5.2.3. **Total Response Score.** The Solicitation Coordinator will calculate the sum of the Technical Response section scores and the Cost Proposal score and record the resulting number as the total score for the subject Response (refer to RFP Attachment 6.5., Score Summary Matrix).

5.3. **Contract Award Process**

5.3.1 The Solicitation Coordinator will submit the Proposal Evaluation Team determinations and scores to the head of the procuring agency for consideration along with any other relevant information that might be available and pertinent to contract award.

5.3.2. The procuring agency head will determine the apparent best-evaluated Response. To effect a contract award to a Respondent other than the one receiving the highest evaluation process score, the head of the procuring agency must provide written justification and obtain the written approval of the Chief Procurement Officer and the Comptroller of the Treasury.

5.3.3. The State will issue a Notice of Intent to Award identifying the apparent best-evaluated response and make the RFP files available for public inspection at the time and date specified in the RFP Section 2, Schedule of Events.

NOTICE: The Notice of Intent to Award shall not create rights, interests, or claims of entitlement in either the apparent best-evaluated Respondent or any other Respondent.

5.3.4. The Respondent identified as offering the apparent best-evaluated response must sign a contract drawn by the State pursuant to this RFP. The Contract shall be substantially the same as the RFP Attachment 6.6., *Pro Forma* Contract. The Respondent must sign the contract by the Contractor Signature Deadline detailed in the RFP Section 2, Schedule of Events. If the Respondent fails to provide the signed Contract by this deadline, the State may determine that the Respondent is non-responsive to this RFP and reject the response.

5.3.5. Notwithstanding the foregoing, the State may, at its sole discretion, entertain limited negotiation prior to Contract signing and, as a result, revise the *pro forma* contract terms and conditions or performance requirements in the State's best interests, PROVIDED THAT such revision of terms and conditions or performance requirements shall NOT materially affect the basis of response evaluations or negatively impact the competitive nature of the RFP and contractor selection process.

5.3.6. If the State determines that a response is non-responsive and rejects it after opening Cost Proposals, the Solicitation Coordinator will re-calculate scores for each remaining responsive Cost Proposal to determine (or re-determine) the apparent best-evaluated response.

RFP # 31786-00143 STATEMENT OF CERTIFICATIONS AND ASSURANCES

The Respondent must sign and complete the Statement of Certifications and Assurances below as required, and it must be included in the Technical Response (as required by RFP Attachment 6.2., Technical Response & Evaluation Guide, Section A, Item A.1.).

The Respondent does, hereby, expressly affirm, declare, confirm, certify, and assure ALL of the following:

1. The Respondent will comply with all of the provisions and requirements of the RFP.
2. The Respondent will provide all services as defined in the Scope of the RFP Attachment 6.6., *Pro Forma* Contract for the total Contract Term.
3. The Respondent, except as otherwise provided in this RFP, accepts and agrees to all terms and conditions set out in the RFP Attachment 6.6., *Pro Forma* Contract.
4. The Respondent acknowledges and agrees that a contract resulting from the RFP shall incorporate, by reference, all proposal responses as a part of the Contract.
5. The Respondent will comply with:
   (a) the laws of the State of Tennessee;
   (b) Title VI of the federal Civil Rights Act of 1964;
   (c) Title IX of the federal Education Amendments Act of 1972;
   (d) the Equal Employment Opportunity Act and the regulations issued there under by the federal government; and,
   (e) the Americans with Disabilities Act of 1990 and the regulations issued there under by the federal government.
6. To the knowledge of the undersigned, the information detailed within the response submitted to this RFP is accurate.
7. The response submitted to this RFP was independently prepared, without collusion, under penalty of perjury.
8. No amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Respondent in connection with this RFP or any resulting contract.
9. Both the Technical Response and the Cost Proposal submitted in response to this RFP shall remain valid for at least 120 days subsequent to the date of the Cost Proposal opening and thereafter in accordance with any contract pursuant to the RFP.
10. The Respondent affirms the following statement, as required by the Iran Divestment Act Tenn. Code Ann. § 12-12-111: "By submission of this bid, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of its knowledge and belief that each bidder is not on the list created pursuant to §12-12-106." For reference purposes, the list is currently available online at: https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/library-/public-information-library.html.

By signing this Statement of Certifications and Assurances, below, the signatory also certifies legal authority to bind the proposing entity to the provisions of this RFP and any contract awarded pursuant to it. If the signatory is not the Respondent (if an individual) or the Respondent's company *President* or *Chief Executive Officer*, this document must attach evidence showing the individual's authority to bind the Respondent.

DO NOT SIGN THIS DOCUMENT IF YOU ARE NOT LEGALLY AUTHORIZED TO BIND THE RESPONDENT

SIGNATURE: _____

PRINTED NAME & TITLE: _____

DATE: _____

RESPONDENT LEGAL ENTITY NAME: _____

TECHNICAL RESPONSE & EVALUATION GUIDE

SECTION A: MANDATORY REQUIREMENTS. The Respondent must address all items detailed below and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the response page number for each item in the appropriate space below.

The Solicitation Coordinator will review the response to determine if the Mandatory Requirement Items are addressed as required and mark each with pass or fail. For each item that is not addressed as required, the Proposal Evaluation Team must review the response and attach a written determination. In addition to the Mandatory Requirement Items, the Solicitation Coordinator will review each response for compliance with all RFP requirements.

RESPONDENT LEGAL ENTITY NAME:			
Proposal Page # (Respondent completes)	**Item Ref.**	**Section A— Mandatory Requirement Items**	**Pass/Fail**
		The Response must be delivered to the State no later than the Response Deadline specified in the RFP Section 2, Schedule of Events.	
		The Technical Response and the Cost Proposal documentation must be packaged separately as required (refer to RFP Section 3.2., *et. seq.*).	
		The Technical Response must NOT contain cost or pricing information of any type.	
		The Technical Response must NOT contain any restrictions of the rights of the State or other qualification of the response.	
		A Respondent must NOT submit alternate responses (refer to RFP Section 3.3.).	
		A Respondent must NOT submit multiple responses in different forms (as a prime and a subcontractor) (refer to RFP Section 3.3.).	
	A.1.	Provide the Statement of Certifications and Assurances (RFP Attachment 6.1.) completed and signed by an individual empowered to bind the Respondent to the provisions of this RFP and any resulting contract. The document must be signed without exception or qualification.	
	A.2.	Provide a statement, based upon reasonable inquiry, of whether the Respondent or any individual who shall cause to deliver goods or perform services under the contract has a possible conflict of interest (*e.g.*, employment by the State of Tennessee) and, if so, the nature of that conflict. NOTE: Any questions of conflict of interest shall be solely within the discretion of the State, and the State reserves the right to cancel any award.	
	A.3.	Provide a current bank reference indicating that the Respondent's business relationship with the financial institution is in positive standing. Such reference must be written in the form of a standard business letter, signed, and dated within the past three (3) months.	
	A.4.	Provide two current positive credit references from vendors with which the Respondent has done business written in the form of standard business letters, signed, and dated within the past three (3) months.	
	A.5.	Provide **EITHER**: (a) Provide an official document or letter from an accredited credit bureau, verified and dated within the last three (3) months and indicating a satisfactory credit score for the Respondent (NOTE: A credit bureau report number without the full report is insufficient and will not be considered responsive.)**OR** (b) Provide a current credit rating from Moody's, Standard & Poor's, A.M. Best or Fitch Ratings, verified and dated within the last three (3) months and indicating a positive credit rating for the Respondent.	

RESPONDENT LEGAL ENTITY NAME:			
Proposal Page # (Respondent completes)	**Item Ref.**	**Section A— Mandatory Requirement Items**	**Pass/Fail**
	A.6.	Provide a copy of the Respondent's URAC (formerly known as Utilization Review Accreditation Commission) Pharmacy Benefit Management accreditation certificate or other proof that URAC Pharmacy Benefit Management accreditation will occur on or before the pharmacy contract effective date. The successful Respondent will be required to maintain URAC Pharmacy Benefit Management accreditation during the entire term of this contract, including runout.	
	A.7.	Provide written confirmation that the Respondent has been operating as a Pharmacy Benefit Manager for a minimum of five (5) years.	
	A.8.	Provide the name of one (1) client with 100,000 or more lives currently receiving PBM services from the Respondent, as well as 2 clients with at least 75,000 lives each.	
	A.9.	Provide written confirmation that the Respondent has complied with all State insurance department filings.	
	A.10.	Provide a statement of your understanding that you will utilize your largest national Formulary for the State and that the State has the sole authority to decide whether certain drugs or drug classes are to be removed from said Formulary.	
	A.11.	Provide the Respondent's most recent independent audited financial statements. Said independent audited financial statements must: (1) reflect an audit period for a fiscal year ended within the last 36 months; (2) be prepared with all monetary amounts detailed in United States currency; (3) be prepared under United States Generally Accepted Accounting Principles (US GAAP); (4) include the auditor's opinion letter; financial statements; and the notes to the financial statements; and (5) be deemed, in the sole discretion of the State to reflect sufficient financial stability to undertake the subject contract with the State if awarded pursuant to this RFP. OR, in lieu of the aforementioned independent audited financial statements, provide a financial institution's letter of commitment for a general Line of Credit in the amount of One Million Seven Hundred Thousand Dollars ($1,700,000.00), U.S. currency, available to the Respondent. Said letter must specify the Respondent's name, be signed and dated within the past three (3) months by an authorized agent of the financial institution, and indicate that the Line of Credit shall be available for a span of five years. NOTES: ▪ Reviewed or Compiled Financial Statements will not be deemed responsive to this requirement and will not be accepted. ▪ All persons, agencies, firms, or other entities that provide opinions regarding the Respondent's financial status must be properly licensed to render such opinions. The State may require the Respondent to submit proof that the person or entity who renders an opinion regarding the Respondent's financial status is licensed, including the license number and state in which the person or entity is licensed.	
	A.12	Provide a written attestation that if awarded the contract the Respondent shall not use information gained through this Contract, including but not limited to utilization and pricing information, in marketing or expanding non-State business relationships or for any pecuniary gain.	
State Use – Solicitation Coordinator Signature, Printed Name & Date:			

TECHNICAL PROPOSAL & EVALUATION GUIDE

SECTION B: GENERAL QUALIFICATIONS & EXPERIENCE. The Respondent must address all items detailed below and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the proposal page number for each item in the appropriate space below. Proposal Evaluation Team Members will independently evaluate and assign one score for all responses to Section B— General Qualifications & Experience Items.

RESPONDENT LEGAL ENTITY NAME:		
Proposal Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
	B.1.	Detail the name, e-mail address, mailing address, telephone number, and facsimile number of the person the State should contact regarding the response.
	B.2.	Describe the Respondent's form of business (*i.e.*, individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and business location (physical location or domicile).
	B.3.	Detail the number of years the Respondent has been in business.
	B.4.	Briefly describe how long the Respondent has been providing the goods or services required by this RFP.
	B.5.	Describe the Respondent's number of employees, client base, and location of offices.
	B.6.	Provide a statement of whether there have been any mergers, acquisitions, or change of control of the Respondent within the last ten (10) years. If so, include an explanation providing relevant details.
	B.7.	Provide a statement of whether the Respondent or, to the Respondent's knowledge, any of the Respondent's employees, agents, independent contractors, or subcontractors, involved in the delivery of goods or performance of services on a contract pursuant to this RFP, have been convicted of, pled guilty to, or pled *nolo contendere* to any felony. If so, include an explanation providing relevant details.
	B.8.	Provide a statement of whether, in the last ten (10) years, the Respondent has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, include an explanation providing relevant details.
	B.9.	Provide a statement of whether there is any material, pending litigation against the Respondent that the Respondent should reasonably believe could adversely affect its ability to meet contract requirements pursuant to this RFP or is likely to have a material adverse effect on the Respondent's financial condition. If such exists, list each separately, explain the relevant details, and attach the opinion of counsel addressing whether and to what extent it would impair the Respondent's performance in a contract pursuant to this RFP. NOTE: All persons, agencies, firms, or other entities that provide legal opinions regarding the Respondent must be properly licensed to render such opinions. The State may require the Respondent to submit proof of license for each person or entity that renders such opinions.
	B.10.	Provide a statement of whether there are any pending or in progress Securities Exchange Commission investigations involving the Respondent. If such exists, list each separately, explain the relevant details, and attach the opinion of counsel addressing whether and to what extent it will impair the Respondent's performance in a contract pursuant to this RFP. NOTE: All persons, agencies, firms, or other entities that provide legal opinions regarding the Respondent must be properly licensed to render such opinions. The State may require the Respondent to submit proof of license for each person or entity that renders such opinions.

RESPONDENT LEGAL ENTITY NAME:		
Proposal Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
	B.11.	Provide a brief, descriptive statement detailing evidence of the Respondent's ability to deliver the goods or services sought under this RFP (*e.g.*, prior experience, training, certifications, resources, program and quality management systems, *etc*.).
	B.12.	Provide a narrative description of the proposed project team, its members, and organizational structure along with an organizational chart identifying the key people who will be assigned to deliver the goods or services required by this RFP.
	B.13.	Provide a personnel roster listing the names of key people who the Respondent will assign to meet the Respondent's requirements under this RFP along with the estimated number of hours that each individual will devote to that performance. Follow the personnel roster with a resume for each of the people listed. The resumes must detail the individual's title, education, current position with the Respondent, and employment history.
	B.14.	Provide a statement of whether the Respondent intends to use subcontractors to meet the Respondent's requirements of any contract awarded pursuant to this RFP, and if so, detail: (a) the names of the subcontractors along with the contact person, mailing address, telephone number, and e-mail address for each; (b) a description of the scope and portions of the goods each subcontractor involved in the delivery of goods or performance of the services each subcontractor will perform; and (c) a statement specifying that each proposed subcontractor has expressly assented to being proposed as a subcontractor in the Respondent's response to this RFP.
	B.15.	Provide documentation of the Respondent's commitment to diversity as represented by the following: (a) Business Strategy. Provide a description of the Respondent's existing programs and procedures designed to encourage and foster commerce with business enterprises owned by minorities, women, service-disabled veterans, persons with disabilities, and small business enterprises. Please also include a list of the Respondent's certifications as a diversity business, if applicable. (b) Business Relationships. Provide a listing of the Respondent's current contracts with business enterprises owned by minorities, women, service-disabled veterans, persons with disabilities, and small business enterprises. Please include the following information: (i) contract description; (ii) contractor name and ownership characteristics (*i.e.*, ethnicity, gender, service-disabled veteran-owned or persons with disabilities); (iii) contractor contact name and telephone number. (c) Estimated Participation. Provide an estimated level of participation by business enterprises owned by minorities, women, service-disabled veterans, persons with disabilities and small business enterprises if a contract is awarded to the Respondent pursuant to this RFP. Please include the following information: (i) a percentage (%) indicating the participation estimate. (Express the estimated participation number as a percentage of the total estimated contract value that will be dedicated to business with subcontractors and supply contractors having such ownership characteristics only and **DO NOT INCLUDE DOLLAR AMOUNTS**); (ii) anticipated goods or services contract descriptions; (iii) names and ownership characteristics (i.e., ethnicity, gender, service-disabled veterans, or disability) of anticipated subcontractors and supply contractors. NOTE: In order to claim status as a Diversity Business Enterprise under this contract, businesses must be certified by the Governor's Office of Diversity Business Enterprise (Go-DBE). Please visit the Go-DBE website at https://tn.diversitysoftware.com/FrontEnd/StartCertification.asp?TN=tn&XID=9810 for more information. (d) Workforce. Provide the percentage of the Respondent's total current employees by ethnicity and

RESPONDENT LEGAL ENTITY NAME:		
Proposal Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
		gender. NOTE: Respondents that demonstrate a commitment to diversity will advance State efforts to expand opportunity to do business with the State as contractors and subcontractors. Response evaluations will recognize the positive qualifications and experience of a Respondent that does business with enterprises owned by minorities, women, service-disabled veterans, persons with disabilities, and small business enterprises and who offer a diverse workforce.
	B.16.	Provide a statement of whether or not the Respondent has any current contracts with the State of Tennessee or has completed any contracts with the State of Tennessee within the previous five (5) year period. If so, provide the following information for all of the current and completed contracts: (a) the name, title, telephone number and e-mail address of the State contact knowledgeable about the contract; (b) the procuring State agency name; (c) a brief description of the contract's scope of services; (d) the contract period; and (e) the contract number. NOTES: ▪ Current or prior contracts with the State are not a prerequisite and are not required for the maximum evaluation score, and the existence of such contracts with the State will not automatically result in the addition or deduction of evaluation points. ▪ Each evaluator will generally consider the results of inquiries by the State regarding all contracts noted.
	B.17.	Provide customer references from individuals who are not current or former State employees for projects similar to the goods or services sought under this RFP and which represent: ▪ two (2) accounts Respondent currently services that are similar in size to the State; and ▪ three (3) completed projects. References from at least three (3) different individuals are required to satisfy the requirements above, e.g., an individual may provide a reference about a completed project and another reference about a currently serviced account. The standard reference questionnaire, which must be used and completed, is provided at RFP Attachment 6.4. References that are not completed as required may be deemed non-responsive and may not be considered. The Respondent will be solely responsible for obtaining fully completed reference questionnaires and including them in the sealed Technical Response. In order to obtain and submit the completed reference questionnaires follow the process below. (a) Add the Respondent's name to the standard reference questionnaire at RFP Attachment 6.4. and make a copy for each reference. (b) Send a reference questionnaire and new, standard #10 envelope to each reference. (c) Instruct the reference to: (i) complete the reference questionnaire; (ii) sign and date the completed reference questionnaire; (iii) seal the completed, signed, and dated reference questionnaire within the envelope provided; (iv) sign his or her name in ink across the sealed portion of the envelope; and (v) return the sealed envelope directly to the Respondent (the Respondent may wish to give each reference a deadline, such that the Respondent will be able to collect all required references in time to include them within the sealed Technical Response). (d) Do NOT open the sealed references upon receipt. (e) Enclose all sealed reference envelopes within a larger, labeled envelope for inclusion in the Technical Response as required. NOTES: ▪ The State will not accept late references or references submitted by any means other than that

RESPONDENT LEGAL ENTITY NAME:		
Proposal Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
		which is described above, and each reference questionnaire submitted must be completed as required. ▪ The State will not review more than the number of required references indicated above. ▪ While the State will base its reference check on the contents of the sealed reference envelopes included in the Technical Response package, the State reserves the right to confirm and clarify information detailed in the completed reference questionnaires, and may consider clarification responses in the evaluation of references. ▪ The State is under no obligation to clarify any reference information.
	B.18.	Provide a statement and any relevant details addressing whether the Respondent is any of the following: (a) is presently debarred, suspended, proposed for debarment, or voluntarily excluded from covered transactions by any federal or state department or agency; (b) has within the past three (3) years, been convicted of, or had a civil judgment rendered against the contracting party from commission of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (c) is presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed above; and has within a three (3) year period preceding the contract had one or more public transactions (federal, state, or local) terminated for cause or default.
	B.19.	Other than the mandatory URAC accreditation, provide information on any accreditations related to the services required under this contract for which your organization has been certified.
		SCORE *(for all Section B—Qualifications & Experience Items above)*: *(maximum possible score = 15)*
State Use – Evaluator Identification:		

TECHNICAL PROPOSAL & EVALUATION GUIDE

SECTION C: TECHNICAL QUALIFICATIONS, EXPERIENCE & APPROACH. The Respondent must address all items (below) and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the response page number for each item in the appropriate space below.

A Proposal Evaluation Team, made up of three or more State employees, will independently evaluate and score the response to each item. Each evaluator will use the following whole number, raw point scale for scoring each item:

0 = little value ***1 = poor*** ***2 = fair*** ***3 = satisfactory*** ***4 = good*** ***5 = excellent***

The Solicitation Coordinator will multiply the Item Score by the associated Evaluation Factor (indicating the relative emphasis of the item in the overall evaluation). The resulting product will be the item's Raw Weighted Score for purposes of calculating the section score as indicated.

RESPONDENT LEGAL ENTITY NAME:	

Proposal Page # (Respondent completes)	Item Ref.	Section C— Technical Qualifications, Experience & Approach Items	Item Score	Evaluation Factor	Raw Weighted Score
	C.1.	Provide a narrative that illustrates the Respondent's understanding of the State's requirements and project schedule.		**3**	
	C.2.	Please describe: (a) Your experience with large-scale (plans covering at least 100,000 lives) PBM implementations; (b) The implementation tasks you deem to be the most important; (e.g. copay and/or coinsurance setup, group setup, accounting structure, etc.) (c) Critical and your ability to successfully manage these tasks; and what you consider to be the biggest implementation risks of this program and how you will mitigate these risks.		**3**	
	C.3.	**<u>Plan Implementation</u>** Describe the steps that will be taken from the contract effective date to ensure the Contractor will be prepared to assume all responsibilities of the Plan Pharmacy program as described in this RFP as of the go-live date specified in Contract Section A.29. (Project Deliverables/Milestones). Include: (a) A detailed project implementation plan; (b) The Respondent's plan to ensure that the transition is seamless for Members; (c) A description of the members on the implementation team, and their roles; (d) Data conversion plan, which includes: 1. A description of how claims adjudicated and open Prior Authorizations (PA) issued under the previous PBM will be loaded into prescription history for Members such that recipients will have a seamless transition. 2. A description of the conversion process from the existing Mail Order Service program(s) to your Mail Order Service program (refill history, access, requirement of new prescriptions, etc.) 3. A description of how current Step Therapy programs will be transitioned over (e.g. proton pump inhibitors, multiple sclerosis drugs, tumor necrosis factor (TNF)/rheumatoid arthritis drugs, and human growth hormones (HGH). (e) Suggested list of Member communications related to the transition including the topic/message for each piece and its respective mail date; and (f) A description of the Formulary and claims accuracy testing processes that occur both during and after implementation.		**5**	

RESPONDENT LEGAL ENTITY NAME:	

Proposal Page # (Respondent completes)	Item Ref.	Section C— Technical Qualifications, Experience & Approach Items	Item Score	Evaluation Factor	Raw Weighted Score
	C.4.	**Staffing** For the proposed account team describe: (a) The Respondent's plan to ensure a smooth transition between the implementation team and ongoing account management team with minimal disruption to the State. Also list the proposed transition date that would occur from implementation team to ongoing account management team; (b) List which members of the implementation team will be part of the ongoing account team and what roles they will play (e.g. Account Manager, Clinical Pharmacist, Account Executive); (c) Describe how the account team will work with the State, outside of scheduled meetings, on an ongoing basis to identify opportunities and respond to issues that arise in the industry to ensure the State manages their pharmacy benefits program in a timely, cost effective, and judicious manner; (d) Describe the account team's access to appropriate executive sponsors to escalate and resolve issues of importance to the State; (e) Notwithstanding this Contract, describe any additional compensation received by account team members to promote or sell additional services offered by your organization (Specialty Pharmacy, disease-state management, etc.); and (f) Any evaluation tools you have in place that would allow the State to provide a formal written evaluation of the account team's performance. Describe how often these tools are utilized and how the results are used to improve performance.		**6**	
	C.5.	**Claims Adjudication** Regarding the Respondent's claims adjudication system and processes please describe or provide: (a) An overview of the POS system and its main capabilities, including the ability to meet, or exceed, all claims processing/adjudication requirements; (b) A description of the Member process when submitting a paper claim for reimbursement and how long a Member can expect to wait for a paper check reimbursement; (c) The claim system edits that are routinely performed and electronic messages that can be transmitted to the pharmacist at the time of dispensing (provide lists of all); (d) How data from mail, network retail, non-network retail, manual retail and specialty claims are integrated with medical data from one or more medical TPAs. List if it is real time or retrospective; (e) The Respondent's ability to implement a Coordination of Benefits model, including possible reimbursement, for Members who have other prescription drug coverage; include how it would work from the Member's perspective; (f) How initial and ongoing testing and auditing of the system for accuracy, timeliness, and quality of the Contractor's services will be accomplished; (g) Your security standards and how data are protected; (h) The flexibility of the POS system and the ability to make changes in the software based upon client needs; (i) The ability of auditors to follow claims through the system so that appropriate pricing and crediting of Rebates can be confirmed; and (j) The Respondent's organization's ability to offer an online prior authorization system to physicians by the 18th month after benefits go-live.		5	
	C.6.	**Claims Payment and Reconciliation** Regarding the Respondent's claims payment processes please describe or provide:		6	

RESPONDENT LEGAL ENTITY NAME:	

Proposal Page # (Respondent completes)	Item Ref.	Section C— Technical Qualifications, Experience & Approach Items	Item Score	Evaluation Factor	Raw Weighted Score
		(a) The capabilities of the claims payment system, specifically those capabilities required in contract Section A.6.; (b) The Respondent's ability to offer Transparency in pricing as defined in contract Section A.2**. NOTE: DO NOT include any pricing in this response; only discuss your process.** The State requires 100% Pass Through Transparent Pricing of all manufacturer Rebates and any other such revenue generated as a result of the filling of State Member pharmaceutical claims – whether pharmaceutical, durable medical equipment or any other type of claim processed through the PBM for which the manufacturer receives any kind of payment and for which any monies are generated to the PBM as a result of said transaction. Included in this Pass Through Transparent Pricing requirement, but not limited to, are: access fees, market share fees, Rebates, Specialty Drug Rebates, onsite pharmacy claims, low day supply claims, Generic Drug claims, Biosimilar Drugs, Formulary access fees, service fees, administrative fees associated with Rebates and marketing grants from pharmaceutical manufacturers, wholesalers and data warehouse contractors; (c) System edits to prevent payment of incomplete or denied claims, or those for Members whose eligibility is not current; and (d) The Respondent's pharmacy payment process and ability to comply with any State prompt pay laws. In the absence of any prompt pay laws in Tennessee for PBMs, BA has instead chosen to use the following language regarding prompt payment of pharmacies: the lesser of 30 days or the contracted turnaround time with the pharmacy. Tenn. Code Ann. § 4-3-1021 requires the BA to compile a report by each July 1 using data from various audit reports completed for BA during the year. These audit reports are developed by BA's benefits consulting firm. BA requires the participation and timely assistance of the Contractor to work with the actuaries and benefits analysts both in and outside the State to ensure that each report is completed timely. **Please note**: Tenn. Code Ann. § 4-3-1021(c)(5) requires a "reconciliation of the pharmacy benefits manager's payments to pharmacies with the state's reimbursement to the pharmacy benefits manager." Describe how your organization will work with the state to ensure that the Division of Benefits Administration will be able to meet this requirement each year.			
	C.7.	**Pharmacy Network** Describe or provide the following information regarding the pharmacy network: (a) Capabilities to build pharmacy networks of up to 30 days retail, 90-Day-At-Retail, Mail Order Service, vaccine pharmacies and specialty pharmacies as described in contract Section A.8; (b) Respondent's understanding and agreement that your company will comply with **any and all Tennessee laws** that apply to these plans including, but not limited to your understanding of the State's any willing provider law (Tenn. Code Ann. § 56-7-2359) and Tenn. Code Ann. § 4-3-1021. Please note that Tenn. Code Ann. § 4-3-1021(a) requires the delivery of this report to key stakeholders and leadership of the General Assembly; (c) Provide a GeoAccess mapping report for your proposed national and statewide retail networks. Use the Member ZIP code file enclosed in Appendix 7.3, to demonstrate that your proposed network meets the criteria described in section A.8.e.1. GeoAccess Analysis instructions and a Sample GeoNetworks Analysis report are shown in Appendices 7.7 and 7.8 or Quest Analytics instructions and sample report are shown in Appendices 7.18 and 7.19; (d) Provide the total number of contracted pharmacies nationwide in your networks (up to 30 day retail, Mail Order Service and Retail 90, specialty, and vaccine networks). Respondent must provide the following four (4) lists that will be utilized in this contract (also include the name of any excluded Retail Pharmacy or pharmacy chain): • 30 day network nationwide pharmacies,		7	

RESPONDENT LEGAL ENTITY NAME:	

Proposal Page # (Respondent completes)	Item Ref.	Section C— Technical Qualifications, Experience & Approach Items	Item Score	Evaluation Factor	Raw Weighted Score
		• Mail Order Service plus nationwide Retail Pharmacy (also referred to as "mail at retail" in the industry), • Specialty pharmacies, and • Vaccine network pharmacies. (e) The frequency of pharmacy network contract renegotiation and renewal; (f) The timing and content of Respondent's standard communication process with network pharmacies for introduction of a new client; and (g) Ability to offer a restricted or "narrow" network at a more aggressively contracted rate should the State choose to implement such a network. Must provide the name(s) of this narrower network(s) and the general makeup of it (national pharmacy chains that are included/excluded, and whether any independent pharmacies in Tennessee are part of it and, if so, a list of those). **DO NOT INCLUDE ANY COSTS IN THE RESPONSE TO THIS QUESTION AND DO NOT OFFER THIS NARROW NETWORK AS SOLE NETWORK OR PART OF COST PROPOSAL**. **NOTE: Respondents MUST use Appendix 7.20 for ZIP Code Classifications and the classifications listed (urban, suburban, rural). The ZIP code list and classifications must match in the Respondent's report. The Respondent may use Quest Analytics instead of GeoAccess. Please see Appendices 7.18 and 7.19 for Instructions and Sample Report.**			
	C.8.	**Mail Order Service** Describe or provide the following information regarding the Mail Order Service pharmacy network: (a) The Mail Order Service facility that would be used for the State operations including the length of time the facility has been in operation; (b) The ability to obtain, and load, open refill files from the State's current Mail Order Service pharmacy/PBM, if available; (c) The current capacity of this facility without staff and technology additions; (d) For this Mail Order Service facility, the average turnaround time in the most recent quarter for prescriptions that: 1. Required intervention (in days) 2. Did not require intervention (in days) 3. Were marked as rush orders (e) The Mail Order Service facility's processes for notifying and working with clients, patients and/or prescribers on each of the following issues: 1. The last refill has been dispensed; 2. A Prior Authorization (PA) is about to expire; 3. Orders that do not include appropriate payments; 4. A prescription may be filled with a less expensive Generic Drug or therapeutic equivalent; 5. Receipt of a prescription with distribution/supply issues; and 6. Lost delivery resolution. (f) Any State and/or Federal laws that prohibit the Mail Order Service facility from: 1. Dispensing any medications (please list); 2. Substituting and dispensing generically available products; and 3. Dispensing medications prescribed by licensed Physician Assistants, Nurse Practitioners, Podiatrists, Optometrists, and Naturopaths certified to prescribe medications by the state in which they practice.		3	
	C.9.	**Specialty Pharmacy** Describe or provide the following information regarding the Specialty Pharmacy network: (a) The criteria used to make additions to the Respondent's Specialty Drug list including a copy of the most recent Specialty Drug list. (b) Respondent's written statement agreeing to comply with the definition of Specialty Drugs listed in contract Section A.2. (c) The Respondent's requirements for a pharmacy to participate in the		7	

RESPONDENT LEGAL ENTITY NAME:	

Proposal Page # (Respondent completes)	Item Ref.	Section C— Technical Qualifications, Experience & Approach Items	Item Score	Evaluation Factor	Raw Weighted Score
		Specialty Network. (d) The shipping and handling policy for specialty products including how the first fill of Specialty Drugs is handled when Members require immediate access. (e) The willingness to ship to the Member's choice of location (e.g. physician's office, infusion center, etc.). (f) Any clinical management/utilization (PA, Step Therapy, etc.) programs in place to assess the appropriateness of therapy prior to dispensing specialty products. (g) Specialty Pharmacy care management capabilities including any unique clinical monitoring and Member assistance provided to Members who utilize the Specialty Pharmacy benefit. Include a description of the access Members have to nurses or pharmacists for consultation and education and any efforts commonly used to improve adherence rates for Specialty Drugs. (h) Confirm or deny if the Specialty, Retail and Mail systems are fully integrated so that a complete patient profile is accessible. (i) The Specialty Drug network that you propose for Members. List any conditions for which will these services apply. (j) The availability of, and the State's access to, Specialty Drug consultants or other staff with Specialty Drug expertise. (k) Timeline for how often Specialty Drug list is updated. (l) Timeline for how often drugs otherwise not classified as "specialty" may be re-classified as specialty by the Respondent as a PBM and how this would affect Members who have been filling them in a 90 day supply through either Mail Order Service or at a Retail Pharmacy. (Reminder that our plan only allows specialty scripts to be filled for a 30 day supply and that they must be filled through a Specialty Pharmacy in the PBM's Specialty Pharmacy Network.) (m) Ability to assist the State with future efforts to move certain Specialty Drugs currently covered under the medical benefit to coverage only under the pharmacy benefit (various Healthcare Common Procedure Coding System (HCPCS) codes which are likely to be self-administered specialty pharmaceuticals). Provide any recommendations as to how the State should proceed with this effort including any anticipated challenges; anticipated positive outcomes; and how the Respondent will work with the State and its medical carriers to implement this process. Please describe the Respondent's prior experience coordinating this change with other large employer groups. (n) List what days and hours are available for each of the 15 most heavily used specialty pharmacies in the Respondent's specialty network. The State likes to see specialty pharmacies that have after work hours and weekend availability to call and speak to a live representative or pharmacist for questions about medications and to fill or refill a specialty medication. (o) Confirm the ability to implement Coinsurance on all Specialty Drugs with a minimum and maximum Member out-of-pocket amount. (p) Describe any program or procedure that the Respondent administers to apply manufacturer patient assistance dollars to the State's participants. Please highlight the responsibility, if any, of the State or Member to participate in these programs *(q)* Describe the ability to block manufacturer/drug discount cards or copay assistance cards from applying to a Member's maximum out of pocket amount artificially at all specialty pharmacies in the network. Please note: *Being self-insured, the State has a vested interest in 1) allowing Members to bring their high cost coinsurance-based specialty pharmaceuticals down, but 2) not artificially giving plan Members more credit toward their annual MOOP than they have actually paid.* (r) Confirm the Respondent's ability to enforce these requirements on any Specialty Pharmacy participating in your Specialty Pharmacy Network as required in contract Section A.8.h.7.			
	C.10.	**<u>Formulary Management</u>**		7	

RESPONDENT LEGAL ENTITY NAME:	

Proposal Page # (Respondent completes)	Item Ref.	Section C— Technical Qualifications, Experience & Approach Items	Item Score	Evaluation Factor	Raw Weighted Score
		The State currently has an open formulary with few exclusions specifically listed in our Plan Document, such as fertility medication. Regarding the Respondent's Formulary management policies, procedures, and processes describe or provide: (a) The process for the continued development, maintenance, implementation, and management of a Formulary that promotes clinically appropriate, safe, quality care for Members while decreasing program costs through appropriate utilization within the most cost-effective therapeutic classes. (b) A copy of the Formulary you intend the State to use if selected as the best evaluated Respondent. Clearly describe if this is an open formulary with no exclusions. (c) A disruption analysis related to a switch from the current Formulary to the new Formulary. Use the list provided in RFP Appendix 7.4.for this analysis. (d) The accommodations and support that shall be provided to streamline Formulary differences/changes that may result. Provide a detailed action plan and proposed communication strategy to Members and providers before a drug is removed from your Formulary or becomes a non-preferred brand to advise them of their options. (e) A list of the Pharmacy & Therapeutics Committee member qualifications (credentials and affiliations). Describe the various disciplines represented. Are any of the voting members also employees of the PBM? (f) Timeline of how often the Respondent validates potential conflicts of interest and reviews the committee for its independence and areas of specialization. (g) The number of times per year (how often, or which months) that your Preferred Drug List (PDL) is updated and the process and timing for adding products new to the market to the Formulary. (h) How Members affected by future Formulary changes are notified and the length of time they have to comply with the changes. (i) Your ability to implement timely Formulary changes, clinical edit requirements, and POS modifications. (j) How Formulary products are selected and what place price has in the placement of drugs on the Formulary. (k) Any Formulary compliance/management programs that you would implement. (l) What specific steps can the Respondent help the State take to increase our Generic Dispensing Rate (GDR)? What do you see as the maximum Generic Drug dispensing rate (GDR) for clients of the State's size and purchasing capacity? (m) Capabilities around pharmacoeconomic modeling to ensure clinically safe and effective pharmaceutical care that yields the highest overall cost effectiveness. (n) Ability to coordinate the Formulary development process and criteria with clinical program requirements. (o) Ability to provide to prescribing physicians and plan Members a secure online portal to initiate, update, and review status of Prior Authorizations and/or related requests. (p) How the Respondent notifies Members/employees and or prescribers when you have an adverse event or a drug recall. (q) Timeline of how often the Formulary (preferred drug list) is updated and when it would be posted on the state-specific splash page (contract Section A.20.d.). (r) Plan to notify Members that a Generic Drug or other drug is becoming available under a future Formulary including copies of any such Member communications. (s) Where on your formulary are the few current biosimilar medications positioned? (t) What steps are you taking to increase their uptake? (u) Do you as a PBM track primary non-fulfillment (first time prescriptions not			

RESPONDENT LEGAL ENTITY NAME:	

Proposal Page # (Respondent completes)	Item Ref.	Section C— Technical Qualifications, Experience & Approach Items	Item Score	Evaluation Factor	Raw Weighted Score
		picked up at a pharmacy)? (v) Do you use the Pharmacy Quality Alliance (PQA) measure to track primary non-fulfillment, and if so, what strategies to you employ to reduce it?			
	C.11.	**Benefit Coverage/Plan Design** Describe your capabilities to support the requirements listed in contract Section A.10. (a) Describe the process of how the Respondent ensures that the state-sponsored plans meet the current requirements of the PPACA at the time of go-live and also as additional guidance is provided by the Federal government during the ensuing years 2021-2024 of this contract. (b) The State wishes to be able to be able to block drug coupons from allowing Members to artificially get credit for the full value, thereby reaching their deductible and/or maximum out of pocket amounts sooner. This would apply to retail, mail, and specialty prescriptions. While we desire to allow Members to utilize drug manufacturer coupons to lower their actual out of pocket Copayment or Coinsurance, the State does not want the full coupon value to be applied to the deductible or MOOP. Please explain in detail how the Respondent can work with the State to implement this process at all pharmacies in the networks. (c) Further, manufacturer Drug coupons cannot be considered revenue and do not count toward Rebates or Rebate guarantees in the calculation and reconciliation of those. Provide a written statement attesting to the Respondent's understanding and agreement with this.		7	
	C.12.	**Clinical Programs** Describe or provide the following information regarding the Respondent's clinical programs: (a) Sample reports that will validate impact or savings from clinical programs such as PA, Step Therapy and therapeutic interchange; (b) How often clinical programs are reviewed to ensure they remain up-to-date; (c) Therapeutic substitution and Generic Drug dispensing program; (d) A detailed description of Step Therapy programs that will target all Brand Drugs for the following drug classes: Proton Pump Inhibitors (PPIs), Angiotensin II Receptor Blockers (ARBs), Angiotensin-Converting Enzyme (ACE) Inhibitors, Antidepressants, Cholesterol lowering medications, Anti-hyperlipidemics, Anti-asthmatics, Pain (Rheumatoid Arthritis/Osteoarthritis), Narcotics, and central analgesics; (e) A detailed description of PA program. Include the timing for authorization requirements, the plan to communicate the findings, and how the Respondent plans to manage this process. (f) The ability to share, at the State's request, the PA criteria and/or decision tree for any or all drugs on the Formulary that have Prior Authorization requirements. Such documents will not be shared with Members, but the State may need to review these for background information. (g) How you inform consumers and prescribers of the reasons for clinical decisions including examples of written notification. (h) Any programs/efforts currently in place focusing on medication adherence. Include the success of these programs to date. (i) Explain how the Respondent would work to reduce the use of opioids and other associated pain medications in our population. Explain the program in detail, including any successes in other large group plans and any weaknesses or difficulties that you have encountered.		5	
	C.13.	**Prospective/Concurrent DUR** Describe or provide the following information regarding the Respondent's Drug		4	

RESPONDENT LEGAL ENTITY NAME:	

Proposal Page # (Respondent completes)	Item Ref.	Section C— Technical Qualifications, Experience & Approach Items	Item Score	Evaluation Factor	Raw Weighted Score
		Utilization Review (DUR) program: (a) The capabilities of the DUR systems and the processes to support them. (b) The system's ability to cross-reference controlled substance prescriptions for various Members in the same household. (c) A full list of the edits used to identify issues such as overutilization, incorrect drug dosages, contraindications, incorrect drug treatments and potential abuse and/or misuse at the point of sale, prior to the medication being dispensed.			
	C.14.	**Retro-DUR** Describe or provide the following information regarding the Respondent's Retro-DUR program: (a) An overview of the Retro-DUR program including how required interventions are identified, timeframes for intervention, who is notified and how, and how outcomes of interventions are documented. (b) Criteria and trends used to identify: a. Providers who practice outside of their peer's norm; b. Members with excessive use of controlled substances. (c) Standard pharmacy lock-in guidelines when Member fraud or abuse is identified. Describe the supporting documentation provided to the State. Describe the ability, when requested by the State, to lock a plan Member into a single pharmacy.		4	
	C.15.	**Financials** Describe the following regarding financials: (a) Explain, in detail, if you made any adjustments to the post-settlement Medi-Span AWPs and, if so, how; (b) The Respondent's brand/Generic Drug indicator source. (c) The Respondent's Maximum Allowable Cost (MAC) pricing program. Include: 1. How it is developed, updated, and how frequently updated; 2. Criteria used for product inclusion and removal from the MAC List; 3. The MAC pricing calculation methodology used to determine the MAC price; 4. The percentage of Generic Drug National Drug Codes (NDC or NDC-11) included on the MAC List; 5. The number of MAC pricing lists you manage. Describe the differences between each list (content, pricing, etc.); and 6. The percentage of your Generic Drug claims that hit the MAC List for your total Book of Business. Are the percentages different for mail and retail? 7. If MAC pricing applies to Generic Drugs dispensed in all pharmacy types (retail, mail, and specialty). (d) A sample of the Dispensing Fee annual reconciliation report that you will provide to the State. (e) A sample of the guaranteed minimum Discount and Dispensing Fee measurement report that you will provide to the State. (f) In instances where a brand prescription drug has considerable market share, provide how quickly the Respondent sets a MAC price for competing Generic Drugs coming to market. (g) Please review Tennessee Code Annotated and for each section that applies to Pharmacy Benefit Managers, list each section of the Tenn. Code Ann.as well as any sub sections and explain how your organization will ensure compliance with these laws. (h) Provide a written statement attesting that the Respondent agrees with the definitions of Transparent and Pass-Through Transparent Pricing in the definitions contract Section A.2. Provide a written statement attesting that the Respondent agrees that the only revenue or profit the Contractor may and will receive are the monthly PMPM Administrative Fees paid by the State, any margin on 90 day		8	

RESPONDENT LEGAL ENTITY NAME:	

Proposal Page # (Respondent completes)	Item Ref.	Section C— Technical Qualifications, Experience & Approach Items	Item Score	Evaluation Factor	Raw Weighted Score
		prescriptions that may be filled by your PBM-owned Mail Order Service pharmacy (if applicable), and any margin on Specialty Drug prescriptions filled by your own PBM-owned Specialty Pharmacy (if applicable).			
	C.16.	**<u>Rebates</u>** Describe the following regarding Rebates: (a) Any minimum Formulary requirements or Formulary management program to participate in Rebate payments. (b) How the State will be notified of Rebate contract changes that may have a material impact. (c) A sample report in which you demonstrate that 100% of Rebates, admin fees and other fees earned from pharmaceutical manufacturers are passed on to the State. (d) Ability to substantiate any Rebate guarantee adjustments, if needed. (e) Ability to provide a breakout with (or before) each Rebate check which shows the total amount of the check and which previous quarters and which groups (e.g. State actives, State retirees, Local Education actives, Local Education retirees, Local Government actives, Local Government retirees) make up each of the amounts. (f) Explain in detail what would occur to your minimum Rebate guarantees if the State decides mid-year to exclude coverage of a particular class of drugs altogether, or to exclude a few different drugs themselves (e.g. combination drugs made of up several Generic Drugs). **Do not include any amounts or details**; rather, the State is mostly interested in whether the State can make this change without any changes to your guaranteed Discounts, Rebates, and rates. (g) The State may implement point-of-sale Rebates – particularly for our CDHP Members. Please describe the ability to provide immediate, point-of-sale Rebates for all of our plan options (currently 3 different types of PPOs and 2 CDHPs) for all brand and Specialty Drugs filled at **<u>any pharmacy</u>** in your 30 day, 90 day, Mail Order Service pharmacy and Specialty Pharmacy networks. Describe how this would look and work from both the Member's and the State's perspective with examples of various drugs and reports that would be provided to the State to substantiate and corroborate Rebate reporting. Describe the ability of an outside auditor to be able to track the full Rebate process to ensure that the State and Members are receiving the full value of the manufacturer Rebate and then sharing that with Members at the point of sale. Describe how you would "true-up" the Rebate yield to provide the State with the 100% Rebate requirement. (h) Provide a written statement attesting that the Respondent agrees or not to the following question (and do not provide any cost figures at all): Does the Respondent charge anything to adjudicate and manage point-of-sale (POS) Rebates?		8	
	C.17.	**<u>Data Integration & Technical Requirements</u>** Please answer each subsection separately and label the responses as such: (a) Ability to interface with the State's Edison ERP system to ensure the accurate and timely processing of enrollment files including eligibility additions, changes, and deletions based on the full population 834 file that will be supplied daily by the State. See Appendix 7.11. (b) Ability to accurately interpret and load the eligibility information provided in the State's 834 including but not limited to all scenarios described in Appendix 7.11. (c) Understanding and ability to make changes to the eligibility file on a manual basis if requested by the State on an as-needed basis. Contractor must not ask State to re-issue another file with the changes included; rather, Contractor must commit that Contractor can and will make manual changes to the file as needed and requested by the State.		5	

RESPONDENT LEGAL ENTITY NAME:	

Proposal Page # (Respondent completes)	Item Ref.	Section C— Technical Qualifications, Experience & Approach Items	Item Score	Evaluation Factor	Raw Weighted Score
		(d) Understanding and agreement that eligibility files will be provided to the Contractor on a daily basis. (e) Understanding and agreement that when the State sends a termination date on the 834 for a Member(s) , the "actual" date that coverage ceases is one day prior. For example, if the term date on a nightly Edison 834 file shows as 7/1/2020, the Member actually terminated coverage and pharmacy benefits should cease on 6/30/2020. Please explain your understanding of this and how you will ensure that your systems adequately capture and make any necessary adjustments to reflect this on a continual basis for all Members. (f) The State requires that the Contractor contact the State eligibility team anytime there are 300 or more terms or drop-offs before the daily eligibility file is loaded. Please describe your ability to do this. (g) The quality control processes the Respondent has in place to ensure the accurate and complete update of eligibility files. Describe how eligibility errors will be communicated to the State. (The State currently uses secure email to send an email with a spreadsheet showing the Member ID and the issue to be worked on and this is how we prefer to continue.) (h) Where duplicate records relating to pharmacy payments are maintained and in what electronic format. (i) Capabilities to transmit pharmacy data and provide daily, weekly or monthly data feeds to any third parties as requested by the State, including but not limited to the Decision Support Services (DSS), health & wellness, medical carriers, employee clinic(s), BHO/EAP, or any State contractor as requested by the State. (j) Ability to provide to and receive from the State's TPAs Member out of pocket costs for deductibles, maximum out of pocket amounts (at both the individual and family levels) for all health plan types offered by the state (currently PPOs and CDHPs). The State requires a Contractor who will work with our TPAs to share pharmacy data accurately and in real time (referred to as "middle tier") and receive medical accumulator dollar data so that Members deductibles and MOOPs can be tracked in real time. i. In addition, please confirm the Respondent's understanding that the State will only share a single standard customized 834 eligibility file with the Contractor and BA's other contractors regularly. (The 834 file is customized, but the "standard" means that the State sends the exact same customized file to all our vendors and we will not customize it for a specific vendor's needs.) When and if accumulator data does not sync correctly, it will be up to the Contractor and/or the TPAs to work together to make the proper adjustments to correct such errors to ensure Member accumulator data are correct. In these instances, the State will not revise our eligibility file. (k) Process for loading historical data from the current PBM and, if requested, using the data to transfer prescriptions to the Respondent's mail and specialty pharmacies. (l) Business continuity and disaster recovery plans (BC-DR) for claims processing, internet, call centers, pharmacies, and information management (data warehouse) systems. Include your system back-up processes. The State is not requesting copies of your actual BC-DR reports or results; rather, we would like to know that you have processes in place and hear more about them in general terms. (m) Please review and, if applicable, please provide any proposed redlines to the State's Enterprise Information Security Policies, see Contract section E.9.a(4). The State document must be the baseline, not the respondent's security policy document. Respondents not proposing any changes need to submit a statement stating there are no redlines proposed.			
	C.18.	**Privacy & Confidentiality** Describe the safeguards to protect the privacy and confidentiality of Members and to prevent unauthorized use or disclosure of Protected Health Information (PHI) that you create, receive, transmit, or maintain related to the Plan		3	

RESPONDENT LEGAL ENTITY NAME:	

Proposal Page # (Respondent completes)	Item Ref.	Section C— Technical Qualifications, Experience & Approach Items	Item Score	Evaluation Factor	Raw Weighted Score
		pharmacy benefit.			
	C.19.	**Appeals** (a) Describe all levels of Member appeals and Member complaint processes. (b) Include a narrative that explains the Respondent understands and a written statement attesting that the Respondent will include, implement, and fully execute on a regular basis a three (3) level appeals process including the right to an independent review organization (IRO) as required by the PPACA, and as described in pro forma contract Section A.21. Contractor shall expressly state in the narrative their understanding of the process defined in contract section A.21 and that they are responsible for the cost of appeals at all three (3) levels.		4	
	C.20.	**Customer Services** Describe or provide the following information regarding customer services: (a) The number of and services related to all toll free lines that will be maintained to meet the various call center requirements outlined in contract Section A.22. Explain if different numbers, or a single number, will be used for Members, pharmacists, and systems inquiries. (b) A detailed description of the operations of your call center(s). Include the location (city and state) of call center(s), hours of operation, staffing projections, and plans for rerouting of calls and in what circumstances that may happen. (c) The duration and scope of training for new customer service representatives and how they will be trained on the State account prior to program implementation. (d) Any ongoing training that will be implemented for the State account. (e) The annual turnover rate for calendar years 2015, 2016, and 2017 of your customer service representatives and customer service management staff. (f) The issue resolution process and timeline expectation for each of the following departments: Member services, pharmacy help desk, systems support, and client services. (g) The flexibility of your call center to handle fluctuations in call volume resulting from program, benefit or enrollment changes. (h) A sample of the quarterly customer service/call center statistics that will be provided to the State. (i) How you assess consumer satisfaction and customer service statistics for calendar year 2017 for three (3) of your key accounts similar in size to the State (approximately 280,000 covered lives). (j) How you track and trend data so that you know when you have a problem related to consumer and client services. Describe your problem escalation and resolution process. (k) Describe your systems architecture to ensure that 100% of ALL customer service calls are recorded and able to be retrieved later for review. (l) Respondent's written statement attesting that 100% of all customer service representatives for whom our Members come intact with will be physically located within the continental United States.		4	
	C.21.	**Member Communication/Materials** Describe or provide the following information regarding Member communication/materials: (a) Sample copies of any standard Member materials to be provided to Members such as network lists, formulary documents, I.D. cards, pharmacy benefit descriptive booklets, and welcome packets. Name the file: [Your Organization's Name] Sample Employee Communication Materials. (b) Ability to provide each Member with a pharmacy benefit identification card within the time frames specified in contract Section A.23.m.2, as well as the ability to customize it to the State's specifications (including, but not limited to, incorporation a full color version of the state's "ParTNers for Health" logo). The State reserves the right to require the removal or		4	

RESPONDENT LEGAL ENTITY NAME:	

Proposal Page # (Respondent completes)	Item Ref.	Section C— Technical Qualifications, Experience & Approach Items	Item Score	Evaluation Factor	Raw Weighted Score
		inclusion of any wording (unlimited in any way) on the pharmacy ID card for plan Members as specified in contract Section A.23.m.1. (c) Respondent's current Mail Order Service pharmacy's capability to provide Members a point-of-sale explanation of pharmacy benefits (EOB), which lists the individual Member's pharmaceutical out-of-pocket expenses, the plan sponsor's costs, and any cost savings opportunities for the Member. Explain the types of Member cost savings opportunities that would be included. (d) Respondent's written statement attesting that the State's Edison ID number will be the sole number used on your Member ID cards and in your systems to identify our plan Members. The Edison ID is an 8-digit (currently 8) number with two leading zeroes. (e) Respondent's written statement attesting that the State has sole right of review and refusal for any and all wording on the pharmacy ID cards. The State will determine what logos and/or names to include or not include on both the front and back of all pharmacy ID cards, including any company logo. The purpose is to ensure Members do not misunderstand where they may or may not fill their prescriptions. Please indicate your full understanding and agreement with this provision.			
	C.22.	**Website** Describe or provide the following information regarding the website(including the Mail Order Service website): (a) All web-based pharmacy services that you currently offer. Include the intended audience for these services (Members, providers, clients, etc.) • The ability to create and maintain a "splash" page (also referred to as a "microsite") that is specific to State similar to the current Pharmacy Benefit Manager's splash page at this site: http://info.caremark.com/stateoftn or the BCBS and Cigna pages at this quick links site : https://www.tn.gov/partnersforhealth/quicklinks.html (b) Security measures utilized to protect Member data/PHI, particularly when ordering online. (c) Ability to provide a fully customizable (from the State's perspective), cobranded, contractor owned-and-operated national website that the State can review for clarity and content no later than 30 days prior to go-live. (d) What solutions can be provided to members regarding drug cost calculators that display up-to-date information about the Formulary tier, Member cost share and utilization management requirements (Step Therapy, quantity limits, or Prior Authorization requirements) for covered prescription drugs. Discuss in detail how one of our Members would be able to go on the website and our splash page and easily navigate your calculator and tool to determine their cost for five (5) different popular medications. (e) Please provide a detailed explanation, with visual examples, of all Member applications that are available at the time of the go-live as well as a brief description of new app based initiatives that will launch during the contract term.		5	
	C.23.	**Reporting & Systems Access** Describe or provide the following information regarding your reporting capabilities: (a) Standard reporting package inclusive of report names, methods of distribution, and refresh frequency. Describe and give a general overview of your reporting system that the State staff may be able to utilize to pull cost and utilization data. (b) A sample monthly operational/performance report as referenced in contract Section A.25.a. (c) Ad-hoc reporting capabilities and the access the State will have to an ad-hoc reporting liaison to assist in the development of ad-hoc reporting requests.		5	

RESPONDENT LEGAL ENTITY NAME:	

Proposal Page # (Respondent completes)	Item Ref.	Section C— Technical Qualifications, Experience & Approach Items	Item Score	Evaluation Factor	Raw Weighted Score
		(d) Capabilities to perform modeling and projections based upon historical utilization. (e) Options available to State staff for on-line access to the Contractor's eligibility system. As specified in contract Section A.25(b), describe how State staff will be able to manually add new Members and how soon after the addition claims can be adjudicated for the Member. (f) A sample financial terms compliance report as specified in contract Section A.25.h. (g) A sample Rebate payment report as specified in contract Section A.25.i (h) A sample open service issue report as specified in contract Section A.25.k. (i) As specified in contract Section A.25(b)describe how State staff in our service center will be provided with various access capabilities (to be determined by the State) to either view, update, or manage eligibility in your online system. For reference, we currently have access to view a Member's claims, update or change eligibility dates, update or change a Member's coverage tier (single to family and vice versa), update or change a Member's enrolled health plan type, and to also use a separate data analysis tool to run detailed ad-hoc claims analysis reports by the Pharmacy Director. Various service level staff have other capabilities specific to their role. Explain your system and how State staff will be able to achieve similar reporting needs with your system and how far back claims history will allow all State staff to view claims.			
	C.24.	**<u>Audits (Internal) and Fraud</u>** Describe or provide the following information regarding your audit and fraud processes and capabilities: (a) How often you audit the accuracy of plan program pricing and overall adjudication accuracy. (b) Audit capabilities including the size of your audit team, their experience, capabilities and the audit related activities they routinely perform with regard to your retail network of pharmacies.		3	
	C.25.	**<u>Pharmacy Audits</u>** Describe or provide the following information regarding your pharmacy audit processes: (a) Ability to perform pharmacy audits. (b) Frequency that your pharmacy network is audited and the percentage that is audited annually on-site. (c) How many pharmacies you audit annually that are located in Tennessee. (d) How pharmacies with consistent or repeat findings are handled and if they are removed from the network. (e) How you recoup funds and the percentage of onsite audit recoveries that will be shared with the State. (f) Your processes to detect and prevent errors, fraud or abusive pharmacy utilization by Members, pharmacies or prescribers. (g) Do you also audit your Mail Order Service and specialty pharmacies?		3	

The Solicitation Coordinator will use this sum and the formula below to calculate the section score. All calculations will use and result in numbers rounded to two (2) places to the right of the decimal point.	**Total Raw Weighted Score:** *(sum of Raw Weighted Scores above)*	
Total Raw Weighted Score / **Maximum Possible Raw Weighted Score** *(i.e., 5 x the sum of item weights above)*	**X 40** *(maximum possible score)*	**= SCORE:**

State Use – Evaluator Identification:

State Use – Solicitation Coordinator Signature, Printed Name & Date:

COST PROPOSAL & SCORING GUIDE

NOTICE: THIS COST PROPOSAL MUST BE COMPLETED EXACTLY AS REQUIRED

COST PROPOSAL SCHEDULE— The Cost Proposal, detailed below, shall indicate the proposed price for goods or services defined in the Scope of Services of the RFP Attachment 6.6., *Pro Forma* Contract and for the entire contract period. The Cost Proposal shall remain valid for at least one hundred twenty (120) days subsequent to the date of the Cost Proposal opening and thereafter in accordance with any contract resulting from this RFP. All monetary amounts shall be in U.S. currency and limited to two (2) places to the right of the decimal point.

NOTICE:

The Evaluation Factor associated with each cost item is for evaluation purposes only. The evaluation factors do NOT and should NOT be construed as any type of volume guarantee or minimum purchase quantity. The evaluation factors shall NOT create rights, interests, or claims of entitlement in the Respondent.

Notwithstanding the cost items herein, pursuant to the second paragraph of the Pro Forma Contract section C.1. (refer to RFP Attachment 6.6.), "The State is under no obligation to request work from the Contractor in any specific dollar amounts or to request any work at all from the Contractor during any period of this Contract."

This Cost Proposal must be signed, in the space below, by an individual empowered to bind the Respondent to the provisions of this RFP and any contract awarded pursuant to it. If said individual is not the President or Chief Executive Officer, this document must attach evidence showing the individual's authority to legally bind the Respondent.

Points are assigned based on the results of the Financial Analytic Model analysis provided to the State by Aon. To provide information on how the financial analytic model calculated please see Appendix 7.1.

The Respondent must fill out the Cost Proposal, and must propose a cost for every cell on every line item. This pricing schedule must be completed in full. Do not skip any cells. If the Respondent fails to detail all cost information for the services proposed as required, the State may determine the proposal to be non-responsive and reject it. The Respondent may propose a cost of zero. The State shall interpret a blank Cost Proposal cell as a zero (0).

The prior claims data amounts provided to Respondents are NOT binding upon the State and do not commit the State to purchase services and/or drugs from the Respondent in any particular quantities, or to purchase any services at all.

IMPORTANT: The State may determine the proposal to be non-responsive and reject it if a Respondent MODIFIES, ADDS TO, MAKES NOTES CONCERNING, OR OTHERWISE QUALIFIES IN ANY WAY THE COST PROPOSAL.

Any discrepancies between the electronic and hard copies, costs listed on the hard copy Cost Proposal will prevail.

Assume Discounts will be based on Medi-Span post-settlement Average Wholesale Price (AWP) methodology for all cost proposal calculations submitted in the Cost Proposal for evaluation (Medi-Span AWP Settlement pricing.) The proposed costs shall indicate the proposed price for providing the entire scope of service including all services as defined in the RFP Attachment 6.6. The costs proposed must use the Medi-Span post-settlement AWP methodology for cost proposal calculations, as described in RFP Section 1.1.1.

As listed in RFP Section 5.2.2., Tenn. Code Ann. § 10-7-504(n)(1)(A) applies to this RFP and response proposals including the Cost Proposal.

The Solicitation Coordinator will open the separately sealed Cost Proposal to ensure the Cost Proposals are filled out completely. Cost Proposals for each apparently responsible Respondent will be forwarded to Aon, an independent actuarial firm, under contract with the Department of Finance & Administration, Division of Benefits Administration. The results from the actuarial analysis will be provided to the Solicitation Coordinator. The Solicitation Coordinator will use the "Total Cost for Table A provided by actuarial firm to Solicitation Coordinator" figure to calculate and record each Cost Proposal score in accordance with RFP Attachment 6.3. Cost Proposal & Scoring Guide.

RESPONDENT SIGNATURE:	
PRINTED NAME & TITLE:	
DATE:	
RESPONDENT LEGAL ENTITY NAME:	

RFP ATTACHMENT 6.3.

RESPONDENT LEGAL ENTITY NAME:

In this Cost Proposal, the State is requesting pricing for the broadest retail network (30 day) available from you as a PBM. The State is also requesting pricing for the broadest 90-day retail network ('mail-at-retail') AND a mail network (90-day) available from you as a PBM.

The Contractor shall use the Medi-Span post-settlement Average Wholesale Price (AWP) methodology for cost proposal calculations. Do not leave any cells blank or enter more than two digits to the right of the decimal point. Information entered into this table will be used by the independent actuarial firm to perform the actuarial analysis. The costs from this analysis will be provided to the Solicitation Coordinator calculate and record each Cost Proposal score.

Cost Item Description	Calendar Year 2020	Calendar Year 2021	Calendar Year 2022	Calendar Year 2023	Calendar Year 2024
FEES (Guaranteed Maximum PMPM)	**$**	**$**	**$**	**$**	**$**
Administration Fee Per Member Per Month	$ xx.xx / PMPM	$ xx.xx / PMPM	$ xx.xx / PMPM	$ xx.xx / PMPM	$ xx.xx / PMPM
Clinical Fee Per Member Per Month (1)	$ xx.xx / PMPM	$ xx.xx / PMPM	$ xx.xx / PMPM	$ xx.xx / PMPM	$ xx.xx / PMPM
DISPENSING FEES (Guaranteed Maximum Per Paid Claim)					
Retail – Brand	$ xx.xx / CLAIM	**$** xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM
Retail – Generic	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM
90-Day Retail – Brand	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM
90-Day Retail – Generic	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM
Mail – Brand	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM
Mail – Generic	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM
All Brand Specialty Pharmacy Claims (2)	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM
RETAIL NETWORK DISCOUNTS (Guaranteed Minimum Average)					
Brand	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)
Generic	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)
90-DAY RETAIL NETWORK DISCOUNTS (Guaranteed Minimum Average)					
Brand	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)
Generic	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)
MAIL NETWORK DISCOUNTS (Guaranteed Minimum Average)					

Brand	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)
Generic	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)
SPECIALTY NETWORK DISCOUNTS (Guaranteed Minimum Average)					
All Brand Specialty Pharmacy Claims [2]	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)	AWP - (XX.XX%)
REBATES per claim [3] [5] (Guaranteed Minimum Rebate Per Claim) [4]					
All Retail Claim Basis (Brand & Generic)	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM
All 90-Day Retail Claim Basis (Brand & Generic)	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM
All Mail Claim Basis (Brand & Generic)	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM
All Brand Specialty Pharmacy Claims [2]	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM	$ xx.xx / CLAIM
Total Cost for Table A provided by actuarial firm to Solicitation Coordinator					

The Solicitation Coordinator will use this sum and the formula in RFP Attachment 6.3. to calculate the Cost Proposal Score. Numbers rounded to two (2) places to the right of the decimal point will be standard for calculations.

[1] Clinical management fee must cover all clinical categories outlined in this proposal.
[2] Any Generic Specialty Pharmacy claims will fall into the retail generic category.
[3] Rebates must be guaranteed on an all-claims basis; not rebateable basis.
[4] See pro forma contract Section A.15. for information regarding guaranteed rebate amounts.
[5] Any and all rebates will apply to any and all plans offered now or in the future by the State of Tennessee Group Insurance Program, regardless of plan type (PPO, POS, HMO, CHDP/HDHP) or enrollment therein.

PMPM fees must be guaranteed regardless of fluctuations in enrollment.

For purposes of pricing, a claim shall be defined as any single processed paid prescription.

Totals for January 1, 2020 through December 31, 2024

EVALUATION COST AMOUNT ALL FIVE YEARS –2020-2024:			
lowest evaluation cost amount from all proposals / **evaluation cost amount being evaluated**	**x 45 (maximum section score)**	**= SCORE:**	

State Use – Solicitation Coordinator Signature, Printed Name & Date:

RFP ATTACHMENT 6.4.

REFERENCE QUESTIONNAIRE

The standard reference questionnaire provided on the following pages of this attachment MUST be completed by all individuals offering a reference for the Respondent.

The Respondent will be solely responsible for obtaining completed reference questionnaires as required (refer to RFP Attachment 6.2., Technical Response & Evaluation Guide, Section B, Item B.17.), and for enclosing the sealed reference envelopes within the Respondent's Technical Response.

RFP # 31786-00143 REFERENCE QUESTIONNAIRE

REFERENCE SUBJECT: RESPONDENT NAME (completed by Respondent before reference is requested)

The "reference subject" specified above, intends to submit a response to the State of Tennessee in response to the Request for Proposals (RFP) indicated. As a part of such response, the reference subject must include a number of completed and sealed reference questionnaires (using this form).

Each individual responding to this reference questionnaire is asked to follow these instructions:

- complete this questionnaire (either using the form provided or an exact duplicate of this document);
- sign and date the completed questionnaire;
- seal the completed, signed, and dated questionnaire in a new standard #10 envelope;
- sign in ink across the sealed portion of the envelope; and
- return the sealed envelope containing the completed questionnaire directly to the reference subject.

(1) What is the name of the individual, company, organization, or entity responding to this reference questionnaire?

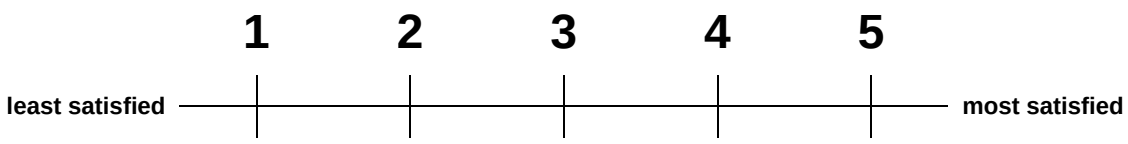
(2) Please provide the following information about the individual completing this reference questionnaire on behalf of the above-named individual, company, organization, or entity.

NAME:	
TITLE:	
TELEPHONE #	
E-MAIL ADDRESS:	

(3) What goods or services does/did the reference subject provide to your company or organization?

(4) What is the level of your overall satisfaction with the reference subject as a vendor of the goods or services described above?

Please respond by circling the appropriate number on the scale below.



If you circled 3 or less above, what could the reference subject have done to improve that rating?

(5) If the goods or services that the reference subject provided to your company or organization are completed, were the goods or services provided in compliance with the terms of the contract, on time, and within budget? If not, please explain.

(6) If the reference subject is still providing goods or services to your company or organization, are these goods or services being provided in compliance with the terms of the contract, on time, and within budget? If not, please explain.

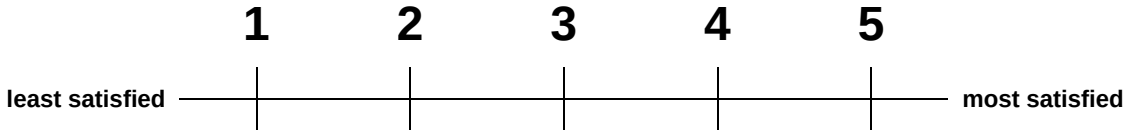
(7) How satisfied are you with the reference subject's ability to perform based on your expectations and according to the contractual arrangements?

(8) In what areas of goods or service delivery does/did the reference subject excel?

(9) In what areas of goods or service delivery does/did the reference subject fall short?

(10) What is the level of your satisfaction with the reference subject's project management structures, processes, and personnel?

Please respond by circling the appropriate number on the scale below.

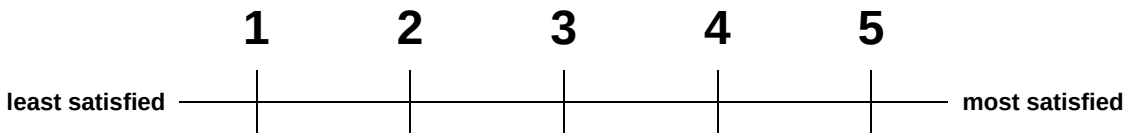


What, if any, comments do you have regarding the score selected above?

RFP # 31786-00143 REFERENCE QUESTIONNAIRE — PAGE 3

(11) Considering the staff assigned by the reference subject to deliver the goods or services described in response to question 3 above, how satisfied are you with the technical abilities, professionalism, and interpersonal skills of the individuals assigned?

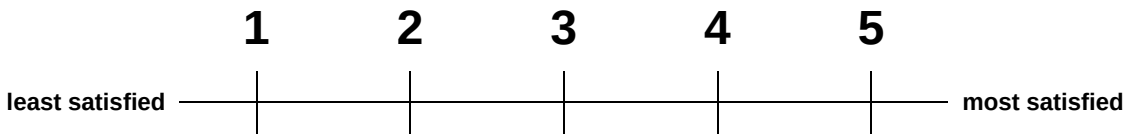
Please respond by circling the appropriate number on the scale below.



What, if any, comments do you have regarding the score selected above?

(12) Would you contract again with the reference subject for the same or similar goods or services?

Please respond by circling the appropriate number on the scale below.



What, if any, comments do you have regarding the score selected above?

REFERENCE SIGNATURE:
(by the individual completing this request for reference information)

(must be the same as the signature across the envelope seal)

DATE:

RFP ATTACHMENT 6.5.

SCORE SUMMARY MATRIX

	RESPONDENT NAME		*RESPONDENT NAME*		*RESPONDENT NAME*	
GENERAL QUALIFICATIONS & EXPERIENCE (maximum: 15)						
EVALUATOR #1						
EVALUATOR #2						
REPEAT AS NECESSARY						
	AVERAGE:		**AVERAGE:**		**AVERAGE:**	
TECHNICAL QUALIFICATIONS, EXPERIENCE & APPROACH (maximum: 40)						
EVALUATOR #1						
EVALUATOR #2						
REPEAT AS NECESSARY						
	AVERAGE:		**AVERAGE:**		**AVERAGE:**	
COST PROPOSAL (maximum: 45)	**SCORE:**		**SCORE:**		**SCORE:**	
TOTAL RESPONSE EVALUATION SCORE: (maximum: 100)						
Solicitation Coordinator Signature, Printed Name & Date:						

RFP #31786-00143 *PRO FORMA* CONTRACT

The *pro forma* contract detailed in following pages of this exhibit contains some "blanks" (signified by descriptions in capital letters) that will be completed with appropriate information in the final contract resulting from the RFP.

CONTRACT
BETWEEN THE STATE OF TENNESSEE,
STATE INSURANCE COMMITTEE,

LOCAL EDUCATION INSURANCE COMMITTEE,
AND LOCAL GOVERNMENT INSURANCE COMMITTEE
AND
CONTRACTOR NAME

This Contract, by and between the State of Tennessee, State Insurance Committee, Local Education Insurance Committee, and the Local Government Insurance Committee ("State") and CONTRACTOR LEGAL ENTITY NAME ("Contractor"), is for the provision of a pharmacy benefits manager for the Public Sector Plans, as further defined in the "SCOPE." State and Contractor may be referred to individually as a "Party" or collectively as the "Parties" to this Contract.

The Contractor is A/AN INDIVIDUAL, FOR-PROFIT CORPORATION, NON-PROFIT CORPORATION, SPECIAL PURPOSE CORPORATION OR ASSOCIATION, PARTNERSHIP, JOINT VENTURE, OR LIMITED LIABILITY COMPANY.
Contractor Place of Incorporation or Organization: LOCATION
Contractor Edison Registration ID # Number

A. SCOPE:

A.1. The Contractor shall provide all service and deliverables as required, described, and detailed herein and shall meet all service and delivery timelines as specified by this Contract.

The Contractor shall provide pharmacy benefit management services, which shall include custom clinical programs as required, specialty care management, Formulary management, network management, Member services, and an online POS pharmacy claims processing system. This POS system shall include a state-wide Retail Pharmacy network, prospective/concurrent DUR, Retro-DUR, utilization management, reporting capabilities, adjudication capabilities, and full pharmacy benefit Member services for retail, Mail Order Service and Specialty Pharmacy benefits for Members.

A.2. Definitions shall be as follows and as set forth in the Contract:

a. **Administrative Fee –** The fee for pharmacy benefit management services paid by the State to the Contractor. The Administrative Fee is the only compensation due the Contractor under the contract, unless the Contractor also bid a Clinical Fee. The Contractor's monthly compensation is a function of the contractor's Administrative Fee multiplied by the number of participating Members per month ("PMPM"). The State recognizes that Clinical Fees are not included in the Administrative Fee The State also recognizes that the Contractor may make a margin on mail and Specialty Drugs that it dispenses out of its own pharmacies.

b. **At-Risk Performance Payment** – Contractor's payment based on KPI performance listed on the SLA Scorecard set forth in Contract Attachment D. The payment is calculated based on the SLA Scorecard quarterly score and percentage of the administrative fees at risk.

c. **Average Seconds to Answer ("ASA"):** The mean time between (a) the moment at which a caller to the Contractor's call center first hears an introductory greeting and enters the queue and (b) the time at which a Member services representative at the call center Answers the call. For this definition, the term "Answer" shall mean begin an uninterrupted dialogue with the caller. If a Member services representative asks the caller to hold during the first sixty (60) seconds of the dialogue, the Contractor shall not consider the call to be Answered for purposes of this definition until the Member services representative returns to the caller and

begins an uninterrupted dialogue. If a caller requested a returned call using the dial-back feature the ASA shall be defined as the time between (a) the moment at which a caller to the Contractor's call center first hears an introductory greeting and enters the queue and (b) the time of the returned call (regardless of whether the Member answered).

d. **AWP -** Average Wholesale Price is a reference price for prescription drug products. Pharmacy reimbursement can be calculated based on AWP minus a percentage. The AWP amount is provided by commercial publishers of drug pricing data such as Medi-Span.

e. **Benefits Administration ("BA") -** The division of the Tennessee Department of Finance & Administration that administers the Public Sector Plans.

f. **Biosimilar Drug -** a type of biological product that is licensed (approved) by the FDA that is highly similar to a biological product already approved by the FDA not withstanding minor differences in clinically inactive components; and that there are no clinically meaningful differences between the biologic product and the reference product in terms of the safety, purity, and potency of the product.

g. **Brand Drug –** The innovator drug product submitted to the FDA for approval and set forth in First Databank's National Drug Data File or Medi-Span's National Drug Data File as a brand drug or brand product. A Brand Drug is a drug produced and distributed with patent protection or after the patent protection has ended, represents the original innovator drug before patent protection ended. For Discount purposes and other related contract calculations, Single-Source Generics should be considered as MS generics and must not be included in the Single Source Brands bucket for the purpose of pricing or guarantee reconciliation.

h. **Business Days** - Traditional workdays, including Monday, Tuesday, Wednesday, Thursday, and Friday. State Government Holidays are excluded.

i. **Clean Claim -** A claim received by the PBM for adjudication, and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the PBM.

j. **Clinical Fee** – The clinical fee (if applicable) paid to the Contractor for their management of clinical programs such as dose optimization programs, generics first programs, safety & monitoring reviews, and prior authorization, quantity limits, and Step Therapy edits as well as prior authorizations and appeals.

k. **Coinsurance** – That percentage of the charge for each drug dispensed to the Member that is the responsibility of the Member.

l. **Compound Prescription –** A prescription that is not commercially available in the strength or quantity prescribed by the physician and meets the following criteria: two (2) or more solid, semi-solid, or liquid ingredients, at least one of which is a covered drug that are weighed and measured then prepared according to the prescriber's order. It excludes the addition of any flavoring to any prescription or medication requiring reconstitution (e.g. powdered oral antibiotics, topical acne preparations, etc.).

m. **Copayment -** That portion of the charge (flat dollar amount) for each drug dispensed to the Member that is the responsibility of the Member.

n. **Day(s) –** Calendar day(s) unless otherwise specified in the Contract.

o. **DEA Number -** A Drug Enforcement Agency Number is a series of numbers assigned to a health care provider allowing them to write prescriptions for controlled substances. The DEA Number is often used as a prescriber identifier.

p. **Denied Claim –** A claim that is not paid for reasons such as eligibility, coverage rules etc.

q. **DESI Drug -** A drug that has been designated as experimental or ineffective by the Food and Drug Administration (FDA).

r. **Disaster -** A negative event or act of nature that significantly disrupts business operations for more than twenty-four (24) hours.

s. **Discount(s)** – The percentage difference between the applicable AWP for a covered service and (i) the Maximum Allowable Cost ("MAC"), where applicable, or (ii) the contractor's negotiated reimbursement amount with a participating pharmacy for prescription drugs, OTCs and other services provided by such pharmacy to Members. The Discount excludes the Dispensing Fee, Copayment and sales tax, if any. For Discount purposes and other related contract calculations, Single-Source Generics should be considered as MS generics and must not be included in the Single Source Brands bucket for the purpose of pricing or guarantee reconciliation.

t. **Dispensing Fee** – An amount paid by the Contractor to a participating pharmacy per claim for providing professional services necessary to dispense medication to a Member.

u. **Dispense as Written-9 ("DAW-9") -** An all-purpose code used whenever an existing code does not accurately describe the note required when a pharmacist or pharmacy technician enters the prescription into the POS system at the pharmacy. These codes are not to be used in any Rebate calculations or reconciliations, as they tend to be a catch-all category that provides no detailed value or information to the State or Pharmacy Benefit Manager.

v. **Decision Support System ("DSS") -** A database and query tool based on health care information and claims data which allows for analytics and executive decision making. Also known as an Executive Information System ("EIS").

w. **Drug Utilization Review ("DUR") -** A POS claim edit to facilitate Drug Utilization Review (DUR) objectives.

x. **Formulary** – The list of clinically appropriate, cost-rational prescription drugs covered by the State health benefit plan/State employee health benefit plan, organized into different 'tiers' or levels indicating how much the Member cost share (Copayment/Coinsurance) will be for each drug.

y. **Generic Code Number ("GCN") -** A standard number assigned by First DataBank (a drug pricing service) to each strength, formulation, and route of administration of a drug entity.

z. **Generic Drug** – A prescription or an OTC drug that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient(s) and approved by the FDA or a drug that is lawfully marketed as a DESI Drug. Generics shall include all drugs with an approved Abbreviated New Drug Application ("ANDA"), single-source generics drugs, MS Generic Drugs, products involved in patent litigation, house Generic Drugs and Generic Drugs that may only be available in limited supply. For Discount purposes and other related contract calculations, Single-Source Generics should be considered as MS generics and must not be included in the Single Source Brands bucket for the purpose of pricing or guarantee reconciliation.

aa. **Generic Product Identifier ("GPI") –** A six-digit code, which includes all drugs sharing the same chemical composition, in the same strength, in the same form and that are administered via the same route.

bb. **House Generic Drug -** a Brand Drug submitted with a Dispense As Written ("DAW") 5 code in place of their generic equivalent and where the pharmacy is reimbursed at a Generic Drug

rate, including MAC, as applicable. For reconciliation of the mail Generic Drug Discount guarantees, the AWP of house generics shall be the average per unit AWP of the generic equivalents, and not the AWP of the Brand Drug.

cc. **In Writing –** Written communication between the Parties, which may be in the form of an official memo, or documents sent via postal mail, fax, or email communications.

dd. **Ingredient Cost** – Will be defined for the Contract according to the criteria below:

1. For retail, Ingredient Cost means the lowest of
    - U&C Price;
    - MAC, where applicable; or
    - AWP less all applicable Discounts or other applicable reimbursement amounts negotiated with the participating Retail Pharmacy and that adheres to the guaranteed AWP Discount percentage set forth in the contractor's pricing.
2. For brands dispensed via the contractor's Mail Order Service and specialty pharmacies, Ingredient Cost means the Discounted price using the guaranteed AWP Discount percentage set forth in the price schedule(s).
3. For generics dispensed via the contractor's Mail Order Service and specialty pharmacies, Ingredient Cost means the lower of the MAC, where applicable, or the Discounted price using the default AWP Discount percentage set forth in the Price Schedule(s). Ingredient Cost does not include the Dispensing Fee, the Copayment, Coinsurance, deductibles or sales tax, if any.

ee. **Identical, Related or Similar ("IRS") -** Drugs that are identical, related or similar to drugs identified as LTE (less than effective) by the FDA.

ff. **Key Performance Indicators ("KPI")** - Performance indicators which are the metrics used to measure and evaluate Contractor's performance against the desired outcomes. These indicators are used to determine Contractor's At-Risk Performance Payment as set forth in Section C and Contract Attachment D.

gg. **Lock In -** A restrictive logic that limits claims at POS to selected prescribers or pharmacies. Members under this restriction are said to be "locked-in".

hh. **Less Than Effective ("LTE") -** Drugs that the Food and Drug Administration (FDA) considers to be Less Than Effective because there is a lack of substantial evidence of effectiveness for all labeled indications and for which there is no compelling justification for their medical need.

ii. **Limited Distribution Specialty Drug -** those Specialty Drugs only available through select pharmacy providers as determined by the drug manufacturer.

jj. **Mail Order Service** – A service whereby medications are delivered via mail including 90-day prescriptions. Mail Order Service is typically used for maintenance drugs taken by Members on a regular basis, such as medication to reduce blood pressure or treat asthma, diabetes, or a chronic heart condition.

kk. **Maximum Allowance Cost ("MAC")** – A cost management program that sets upper limits on the payment for equivalent drugs available from multiple manufacturers. It is the highest unit price that will be paid for a drug and is designed to increase generic dispensing, to ensure the pharmacy dispenses economically, and to control future cost increases.

ll. **MAC List** – A list of Multi-source drugs that are reimbursed at an upper limit per unit price. The list is developed and maintained by the Contractor and is usually reviewed quarterly but individual drug prices may be adjusted more frequently. MAC Lists vary among PBMs. Considerations for inclusion on the MAC list include: availability of the Generic Drug from multiple manufacturers; clinical implications of generic substitution; national availability of generic versions; price differences between the brand and generic; therapeutic equivalence; and volume of claims.

mm. **Medication Therapy Management ("MTM")** – a pharmacist provided service that includes: (1) complete review of all medications, including herbals and over-the-counter products; (2.) personal medication record (e.g. drugs, instructions, prescribers, allergies, problems); (3.) medication action plan for the patient; (4.) intervention and/or referral to other healthcare providers; and (5.) documentation.

nn. **Member -** Eligible employees and their dependents, retirees and their dependents and/or survivors, and individuals qualified under The Federal Consolidated Omnibus Budget Reconciliation Act ("COBRA") and their dependents, who are enrolled in the health plan options sponsored by the State, Local Education, and Local Government Insurance Committees.

oo. **Middle Tier** – A claims trading format which allows near real time trading of deductibles, maximum out of pocket amounts and other such accumulator data for integrated plans between two or more contractors, for the purpose of maintaining in real time Member and family deductibles and maximum out of pocket costs (pharmacy and medical combined).

pp. **Multi-source ("MS")** - Brands and Generic Drugs available from more than one source.

qq. **National Council of Prescription Drug Programs ("NCPDP") -** A not-for-profit American National Standards Institute ("ANSI") Accredited Standards Development Organization.

rr. **National Drug Code ("NDC" or "NDC-11")** – A universal product identifier. The National Drug Code (NDC) Number is a unique, eleven-digit, three-segment number that identifies the labeler/vendor, product, and trade package size.

ss. **National Provider Identification Number ("NPI") -** A 10-position, intelligence-free numeric identifier (10-digit number). The numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty.

tt. **Paid Claim –** A claim that meets all plan established coverage criteria and is paid by the PBM and submitted to the plan for reimbursement.

uu. **Pass-Through Transparent Pricing** – An arrangement whereby the client receives the full value (100%) of the Contractor's negotiated Discounts and Dispensing Fees at retail, and the full value of Rebates. The contractor's only profits are the Administrative Fee and any clinical program fee, and any margin they make for mail prescriptions and specialty prescriptions filled through the Contractor's own Specialty Pharmacy. All financial negotiated Retail Pharmacy contracts and Rebate contracts are fully disclosed to and auditable by the client. The client is protected in this model by requiring guaranteed Discounts, fees, and Rebates from the PBM Contractor. Discounts and Rebates achieved on the client's behalf that exceed the financial guarantees are payable to the client. Dispensing Fees that are paid lower than the guaranteed are also passed through to the client. Hence, the financial guarantees are the minimum Discounts and Rebates the client will achieve and the maximum Dispensing Fees and Administrative Fees the client will pay.

vv. **PPACA –** the federal Patient Protection and Affordable Care Act, Public Law 111-148**.**

ww. **PPO** - Preferred Provider Organization.

xx. **Pharmacy Benefit Manager** ("**PBM")** – State's Contractor which provides pharmacy benefit management services.

yy. **Pharmacy and Therapeutics ("P&T") Committee** - A panel of experts consisting of physicians, pharmacists and clinical experts who assist PBMs in developing Formularies and preferred drug lists which are clinically appropriate and cost rational.

zz. **Physician Profiling-** A means of comparing prescribing behaviors (or other medical orders) among doctors in order to benchmark and/or improve quality of care by providing physicians with meaningful information on their clinical performances. Hence, the success of profiling should be measured by evidence of improvement over time in the structures, processes, and outcomes of care. Physician information is often sorted by specialty or diagnosis, and profiling can be used in a managed care setting as an incentive for quality improvement. Physicians are often given data such as that listed below at monthly or quarterly intervals:

- Formulary compliance
- Generic utilization
- mail/retail
- top drugs by cost
- top drugs by # of prescriptions
- total prescriptions
- total cost to the plan

aaa. **Plan Documents -** The legal publication that defines eligibility, enrollment, benefits and administrative rules of the Public Sector Plans and are posted on the BA website.

bbb. **PMPM** - Per Member Per Month

ccc. **Protected Health Information ("PHI") -** As defined in the HIPAA Privacy Rule, 45 CFR § 160.103.

ddd. **POS -** Point-of-Sale.

eee. **Pre-Service Appeals** – an appeal from a covered plan member or prescribing clinician before the plan member initiates actual filling of a prescription at a retail, mail order, or specialty pharmacy. Such an appeal may come in the form of a prior authorization request from the prescriber in which case the Contractor will render an approval and prior authorization number and length of time the authorization is approved or a denial on the PA request.

fff. **Post-Service Appeals** – an appeal from a covered plan member or prescribing clinician after the plan member or prescribing physician's initial request for initial prior authorization is denied and the next level of appeal is then initiated.

ggg. **Prior Authorization ("PA") -** A program requirement where certain therapies must gain approval before payment can be authorized.

hhh. **Public Key Infrastructure ("PKI")** - The framework and services that provide for the generation, production, distribution, control, accounting, and destruction of public key certificates. Components include the personnel, policies, processes, server platforms, software, and workstations used for the purpose of administering certificates and public-

private key pairs, including the ability to issue, maintain, recover, and revoke public key certificates.

iii. **Public Sector Plans ("Plan") -** Refers to all benefit options sponsored by the State, Local Government, and Local Education Insurance Committees (e.g. health plan options, life insurance, other voluntary benefits). The Plan is available to eligible employees and dependents of participating State (Central State and Higher Education), Local Government, and Local Education agencies.

jjj. **Rebates -** All revenue received by the Contractor from outside sources related to the Plan's utilization or enrollment in programs also known as Total Manufacturer Value. Also, the amounts paid to the contractor (i) pursuant to the terms of an agreement with a pharmaceutical manufacturer, (ii) in consideration for the inclusion of such manufacturer's drug(s) on the Contractor's Formulary, and (iii) which are directly related and attributable to, and calculated based upon, the specific and identifiable utilization of certain prescription drugs by Members. These would include: access fees, market share fees, Rebates, Specialty Drug Rebates, onsite pharmacy claims, low day supply claims, Generic Drug claims, Biosimilar Drugs, Formulary access fees, service fees, Rebate Administrative Fees and marketing grants from pharmaceutical manufacturers, wholesalers and data warehouse contractors, Discounts, credits, inflation protection, charge backs, commissions, and any fees received for sales of utilization data to a pharmaceutical manufacturer. Rebates will also exclude purchase Discounts (e.g. prompt pay Discounts) from mail and specialty products. Further, Drug manufacturer coupons cannot be considered manufacturer revenue and do not count toward the calculation or reconciliation of Rebates. DAW-9 claims are to be excluded from the calculation of Rebate guarantees.

kkk. **Retail Pharmacy** – A Retail Pharmacy establishment at which prescription drugs are dispensed by a registered pharmacist under the laws of each state.

lll. **Retail Pharmacy 90-Day Network or 90-Day-At-Retail** – A network Retail Pharmacy that offers a 90-day ('mail at retail') supply of medications for chronic conditions also known as maintenance medications. The Discounts, Dispensing Fees and Rebates are significantly better than retail and similar to mail.

mmm. **Retrospective DUR ("Retro-DUR")-** A post payment claims analysis to facilitate Drug Utilization Review (DUR) objectives.

nnn. **Secure File Transfer Protocol ("SFTP")** - SFTP is a secure file transfer protocol. It runs over the SSH (Secure SHell) protocol. It supports the full security and authentication functionality of SSH. SFTP can furthermore be used for file sharing, similar to Windows file sharing and Linux NFS. SFTP supports both interactive and automated file transfers.

ooo. **Service Level Agreement ("SLA") Scorecard** – Performance management scorecard that contains Contractor's KPIs and desired outcomes in Contract Attachment D. The At-Risk Performance Payments will be based on the Contractor's ability to meet the listed KPIs.

ppp. **Specialty Drugs** – Specialty Drugs must meet at least two of the first four criteria (1 thru 4) below and the final criteria (5)-

1. Produced through DNA technology or biological processes
2. Targets a chronic or complex disease
3. Route of administration could be inhaled, infused, injected, or oral
4. Unique handling, distribution, and/or administration requirements

5. Requires a customized medication management program that includes medication use review, patient training, and coordination of care and adherence management for successful use such that more frequent monitoring and training is required.

qqq. **Specialty Pharmacy** – A pharmacy that dispenses Specialty Drugs to patients focusing on additional services such as enhanced clinical management, increased adherence, guideline management, and enhanced distribution services.

rrr. **Spread -** A term applicable to traditional pricing wherein the PBM Contractor retains the differential between negotiated contracts and financial terms offered to the client. For example, the PBM may have a higher Discount with pharmacies than it offers to its clients and retain the difference or "spread" as profit. With the traditional model, the "spread" represents the PBMs profit, but the actual amount of this profit may not be fully disclosed to the client.

sss. **State, Local Government, and Local Education Insurance Committees -** Policy making bodies for the State, Local Government, and Local Education agencies under the Public Sector Plans established under Tenn. Code Ann. § 8-27-101, 8-27-207, and 8-27-301 respectively.

ttt. **Step Therapy -** The practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug, and stepping up through a sequence of alternative drug therapies as preceding treatment option fails. Step Therapy programs apply coverage rules at the point of service when a claim is adjudicated. If a claim is submitted for a second-line drug and the Step Therapy rule was not met, the claim is rejected, and a message is transmitted to the pharmacy indicating that the patient should be treated with the first-line drug before coverage of the second-line drug can be authorized.

uuu. **Third Party Administrator ("TPA"):** The State's contracted medical contractor(s) responsible for processing medical claims and providing other administrative support for the contract.

vvv. **Total Manufacturer Value –** See Rebates

www. **Transparent (Pass Through)** – An arrangement pursuant to which the Contractor discloses all sources of revenue, including revenue from network pharmacy contracts and from prescription drug manufacturers, directly attributable to and specifically derived from utilization of prescription drugs by the Contractor's plan Members. Pass-through Transparent Pricing is fully auditable by the client including all pharmacy and drug manufacturer contracts.

xxx. **Usual and Customary ("U&C") –** Retail price charged by a participating pharmacy for the particular drug in a cash transaction on the date the drug is dispensed, as reported by the Retail Pharmacy. U&C shall include all applicable customer Discounts (e.g., generic promotion, special customer, senior citizen, frequent shopper, Discount club, Discount card program, etc.).

yyy. **URAC** – URAC is an independent, nonprofit organization that promotes health care quality through its accreditation and certification programs. Originally, URAC was incorporated under the name Utilization Review Accreditation Commission. However, that name was shortened to the acronym URAC in 1996 when URAC began accrediting other types of organizations such as health plans and preferred provider organizations.

zzz. **Zero Balance Due or ZBD** – a claim in which the full cost is covered by a member's cost share, which results in a zero balance due to the client. ZBD claims are calculated at the

original discounted ingredient cost prior to the application of the member copay and are not artificially inflated to a 100% discount or zero dollar amount.

A.3. Pharmacy Benefit and Policies

a. The State will determine all pharmacy benefits and related policies. If the Contractor has a question on policy determinations, benefits, or operating guidelines required for proper performance of the Contractor's responsibilities, the Contractor shall request In Writing a determination by the State. The State will respond In Writing with a final determination and the Contractor shall then act in accordance with such policy determinations and/or operating guidelines.

b. The State will have the sole responsibility for and authority to clarify and/or revise the Plan Documents which governs the structure of the pharmacy benefits available to Members. The program cannot and does not cover all benefit situations. In a case where the benefits are not referenced or are not clear, the Contractor shall clarify In Writing the State's intent with the State. The State shall have the exclusive and final authority to interpret the Plan Documents.

c. Unless otherwise directed by the State In Writing, the Contractor shall not attempt to interpret statutes, regulations, plan documents, or policy materials. Rather, the Contractor shall refer, In Writing, all questions regarding a policy interpretation to the contact designated by the State within one (1) Business Day of discovery of the issue in question.

d. The Contractor shall possess and maintain full Pharmacy Benefit Management accreditation status with URAC during the entire term of this contract.

A.4. Plan Implementation

a. The pharmacy benefit for the Public Sector Plans will take effect and be fully operational on the go-live date specified in Contract Section A.30.

b. The Contractor shall implement the systems required to process all Plan pharmacy claims and all other services described herein. The Contractor shall work with the State to ensure that the program satisfies the functional and informational requirements as outlined by this Scope and in the Plan Document.

c. The Contractor shall provide a dedicated full-time implementation team. All of the Contractor's implementation team members shall have participated, as team members, in the implementation of pharmacy benefit services for at least one other large employer (employers with pharmacy plans covering at least 100,000 lives). The Contractor's implementation team shall include a full-time licensed pharmacist designated to this Contract, and a full-time account manager designated to this Contract, who will be the main contact with the State for all of the day-to-day matters relating to the implementation and ongoing operations of the Contract. Also, the Contractor shall assign an information systems

project coordinator to coordinate activities among the Contractor and the State's existing contractors and any affected state agencies other than Benefits Administration (including Edison, Strategic Technology Solutions, Department of Human Resources) and other state contractors (including the current PBM, TPAs, DSS contractor).

d. All key Contractor project staff shall attend a project kick-off meeting at the State of Tennessee offices in Nashville, TN within the first thirty (30) days after the Effective Date, as requested by the State. State project staff shall provide access and orientation to the Plan and system documentation, as requested by the Contractor.

e. The Contractor shall provide a project implementation plan as specified in Contract Section A.30. The plan shall be electronically maintained daily in Microsoft Excel or Microsoft Project. The plan shall detail all aspects of implementation, which includes all tasks with deliverable dates necessary to satisfactorily install the program no later than the go-live date specified in Contract Section A.30 and a description of the members on the transition team and their roles. The plan shall include a detailed timeline description of all work to be performed both by the Contractor and the State. This plan shall require written approval by the State. At a minimum, the implementation plan shall provide specific details on the following:

(1) Identification and timing of significant responsibilities and tasks;

(2) Names and titles of key implementation staff;

(3) Identification and timing of the State's responsibilities;

(4) Data requirements (indicate type and format of data required);

(5) Data conversion plan including procedures for testing the conversion data;

(6) Identification and timing for the testing, acceptance and certification of receipt of State's eligibility through Edison;

(7) Identification and timing for testing and certification of claims payment and reconciliation process;

(8) Drug Formulary development consistent with the State pharmacy benefit;

(9) Plan Member communications;

(10) Schedule of in-person meeting and conference calls;

(11) Transition requirements with the incumbent PBM; and

(12) Staff assigned to attend and present (if required) at open enrollment/ educational sessions.

f. The Contractor shall schedule an on-site implementation meeting at the State of Tennessee offices in Nashville, TN as specified in Contract Section A.30.

g. The Contractor shall provide a comprehensive operational readiness review (pre implementation audit) to the State at least sixty (60) days prior to the pharmacy benefit go-live date, as long as the State and the Contractor have met all implementation milestones necessary for the audit. The Contractor shall pay for the comprehensive readiness review to ensure the plan design, eligibility and financial contract terms have been set up correctly.

Such review by the State may include, but not be limited to, an on-site review of the Contractor's operational readiness for all services required in this contract. The review may also include desk reviews of documentation that includes but is not limited to:

(1) Policy and procedures manual;

(2) Information systems;

(3) Any and all deliverables and reports;

(4) System testing for all plan options (PPOs, CDHPs, etc.) for correct member cost share (deductible, copayments and/or coinsurance) for generics, preferred brand drugs, non-preferred brand drugs at both mail order and retail pharmacies and at 30 day and 90 day supplies as well as maintenance tier medications at lower cost share for those filled in a 90 day supply; and

(5) Copies of Contractor's proposed member handbooks or welcome letters/kits and the front and back of the Contractors' proposed pharmacy benefits ID card for plan members for the term of this contract.

h. At its discretion, the State may conduct an additional, pre-implementation review of the Contractor's progress towards fulfilling the IT and telecommunication technology requirements.

i. At the State's request, the Contractor shall host one or more officials of the State onsite at its call center no later than one (1) month prior to the go-live date to ensure that all customer service representatives have been adequately trained on all aspects of the State's unique benefit plans (to ensure that accurate benefits and information will be provided to our Members after go-live). A tour of the facility and a review of the plan of benefits and go-live date will be reviewed as well. These State officials will help to coordinate activities with BA staff and the Contractor's call center.

j. The Contractor shall conduct status meetings concerning project development, project implementation, and Contractor performance weekly during implementation and daily for the first month following the go-live date, unless otherwise approved by the State. Thereafter, all ongoing operational meetings shall be conducted on a State specified schedule, but shall occur no less than once a month. Such meetings shall be either by phone or on-site at the offices of the State, as determined by the State and shall include the Contractor's account manager, pharmacist and appropriate systems staff. Any costs incurred by the Contractor as a result of a meeting with the State shall be the responsibility of the Contractor. In lieu of monthly meetings, the State may choose to hold such meetings via regular teleconference calls with Contractor staff on an as-needed basis, subject to State staff needs.

k. No later than forty-five (45) days post-implementation, the Contractor shall provide the State with an implementation performance assessment, which will be completed and provided back to the Contractor. This assessment will be used to document the State's satisfaction with the implementation process.

A.5. Staffing

a. The Contractor shall provide an ongoing designated, full-time account team that can provide daily operational support as well as strategic planning and analysis. All members of the account team shall have previous experience administering pharmacy benefits for large employers.

b. The account team shall be available for consultation with the State during the hours of 8:00 a.m. to 4:30 p.m. Central Time, Monday through Friday.

c. The Contractor shall designate a full time licensed chief pharmacist as a member of the ongoing account team. This individual shall have over five (5) years' experience working at the executive level for a PBM and shall have the responsibility for providing the State with clinical pharmacological advice in the review and development of a specific Formulary for the Plan, pharmacy benefit design and utilization review activities to include prior authorization (PA), Step Therapy, and other innovative approaches to managing the prescription drug benefits for the Plan. The Clinical Pharmacist shall have experience working as a clinical pharmacist on an account team with at least one employer group or client with a minimum of 100,000 covered lives. In addition, the Contractor shall, at the State's request, have said pharmacist available to participate with the State's wellness contractor and/or case managers at the State's TPAs in regular (or as needed) calls to discuss complex Member cases, Member issues, poly pharmacy issues, and other similar issues. These discussions will typically take place via teleconference on an as-needed basis as determined by the case managers and/or the medical director at the State's wellness contractor.

d. The Contractor shall designate a full time account manager as a member of the ongoing account team. The account manager shall be a member of the implementation team in order to ensure a seamless transition from implementation to ongoing operations.

e. The account manager shall have the responsibility and authority to manage the entire range of services and shall respond immediately to changes in benefit plan design, changes in claims processing procedures, or general administrative problems identified by the State. Further, this account manager shall be someone who is readily available via telephone and email throughout the Business Day to answer calls and emails by the Director of Pharmacy Services at the State and also by other State staff to research Member issues.

f. At a minimum, the account manager shall meet in person with the State once a month and more often if requested by the State. At its discretion, the State may allow the Contractor to participate in such meetings by teleconference.

g. The Contractor shall survey the State annually during the contract period to determine the State's satisfaction with the ongoing account team. Results of the survey should be included in the State's mid-year review, if not sooner.

h. The Contractor shall train all Contractor staff and subcontractors regarding all applicable aspects of the Plan pharmacy program. The State shall approve the Contractor's subcontractors or its staff as defined in this Contract Section. Core services are defined as those that touch or affect the Member, specifically Member customer services, Member call

center, mail and Specialty Pharmacy services (if used by the Member), claims processing and adjudication, appeals processing at all levels. Also included are such services that affect the plan administrator such as the Contractor's account team that interacts with the State on a daily basis through telephone calls, emails, and face to face meetings, clinical advisors or pharmacists on the account team, and the Contractor's pharmacy & therapeutics ("P&T") committee which develops the Contractor's standard national drug Formulary.

i. At the State's request, the Contractor must replace staff members or subcontractors providing core services. The decision of the State on these matters shall not be subject to appeal.

j. Key personnel commitments (implementation or ongoing account manager and chief pharmacist) made in the Contractor's proposal shall not be changed unless the Contractor receives prior approval In Writing from the State. The Contractor shall notify the State at least fifteen (15) Business Days in advance, or as soon as the information is available, of proposed changes and shall submit justification (including proposed substitutions) in sufficient detail regarding education and experience equal to previous staff to the State to evaluate the impact. The decision of the State on these matters shall not be subject to appeal.

k. Key staff on the Contractor's account team includes an Account Manager, Strategic Account Executive, and Clinical Pharmacist. The Strategic Account Executive has overall responsibility for the state contract and ensuring that all contract requirements are met, the majority of reports and other deliverables are provided and that the benefits are executed properly as well as providing long term vision and feedback of plan benefits and working on fiscal notes with State staff. The Account Manager has responsibility for day-to-day operations and management of the pharmacy benefits, member issues, account issues, and interfacing with the State's service center team leads on member or eligibility issues that may arise. The Clinical Pharmacist is responsible for formulary development and discussion as well as assisting State staff on any clinical issues that may arise. If any of these key positions become vacant, Contractor shall provide a replacement with commensurate experience and required professional credentials within sixty (60) days of the vacancy unless the State grants an exception to this requirement In Writing.

l. For matters designated as urgent by the State, the Contractor shall provide a response to the State within four (4) hours. Staff members, from the respective business unit, with final decision making authority shall provide responses.

m. The Contractor, if requested by the State, shall participate in review meetings with the State on a monthly basis for the first six (6) months and quarterly thereafter. In these meetings, the Contractor's account team and the State will review the operations and financial performance of the Plan pharmacy benefit. These meetings will take place at the State of Tennessee offices in Nashville, TN. However, at its discretion, the State may allow the Contractor to participate in such meetings by teleconference.

n. Contractor shall employ no employees or contract with subcontractors that are on the U.S. Department of Health and Human Services' Office of Inspector General (OIG) exclusions list unless the Contractor receives prior approval In Writing from the State.

A.6. Point-of-Sale Claims Adjudication (for Retail, Mail Order, and Specialty Pharmacy)

a. The Contractor shall provide an integrated, electronic retail, Mail Order Service and Specialty POS claims processing system that can meet the needs of the State and the Plan.

b. The Contractor shall provide system design, modification, development, implementation and operation for the Plan POS system, which uses the specified, current NCPDP format. The Contractor's POS system shall allow it to interface with the existing pharmacy switch networks that connect pharmacy providers with the Contractor's system.

c. The POS system shall automate the entire pharmacy claims processing system and shall price and adjudicate claims online and in real time. The POS system shall adjudicate and process all retail, Specialty and Mail Order Service electronic POS and paper claims incurred during the Term in strict accordance with the State's pharmacy benefits as contained in the Plan Document, which is located on the State's website. (https://www.tn.gov/partnersforhealth/publications/publications.html) in the publications section (three (3) Plan Documents for the Plan).

d. The Contractor shall process ninety-nine and one half percent (99.5%) of POS claims on a daily basis within five (5) seconds. For this calculation the number of claims processed within five (5) seconds during each twenty-four (24) hour period shall be the numerator and the number of claims processed during each twenty-four (24) hour period shall be the denominator. To measure compliance with this standard, the Contractor shall measure for each claim the time from when the claim is received by the Contractor's processor to the time the results are transmitted from the Contractor's processor. The Contractor's measure shall reflect the time required for all procedures required to complete claim adjudication.

e. The Contractor shall notify the State's pharmacy director, via e-mail and phone, immediately upon knowledge of unscheduled or unapproved downtime involving more than ten percent (10%) of production for fifteen (15) minutes or longer. The Contractor shall also provide the State updates at regular intervals during a sustained downtime. The State will be presented with recovery options as appropriate. Upon full system recovery, the Contractor shall provide the State with a system downtime analysis describing root cause issues and actions to mitigate future downtime occurrences.

f. Enrolled network pharmacy providers such as retail pharmacies, Specialty Pharmacies, outpatient hospital retail pharmacies and Mail Order Service pharmacies shall be responsible for submitting Member claims through POS telecommunications devices. However, the Contractor shall also process paper claims within thirty (30) days of receipt when submitted by Members or by a prescriber on behalf of a Member.

g. The Contractor shall ensure that retail network claims submitted by network pharmacy providers will be paperless for the Members. The Contractor's agreement with network pharmacy providers shall obligate the network pharmacy providers to submit claims directly to the Contractor.

h. The Contractor's system's must provide Members a POS explanation of pharmacy benefits for claims processed through its mail service and Specialty Pharmacies, and concurrently provide online claims records for prescriptions dispensed through all channels, which lists the individual Member's pharmaceutical out-of-pocket expenses and the Plan sponsor's costs.

i. The Contractor shall work as needed and as requested with the State's TPAs in their work related to subrogation claims. The Contractor shall share data or support the TPAs as needed.

j. The POS claims system shall fully integrate the Prior Authorization, Quantity Limits, and Step Therapy programs, as described in Sections A.12.g and A.12.h, and have edits to verify eligibility, the current Formulary, and claim completeness as claims are submitted.

k. The Contractor shall provide Plan pharmacy services only to eligible Members. The Contractor shall confirm eligibility of each Member on the basis of enrollment information provided by the State, which applies to the period during which the charges were incurred. On a quarterly basis, the Contractor shall accurately process a minimum of ninety-eight percent (98%) of claims either filed directly by Members and/or their prescriber(s), in accordance with Contract Attachment D. Claims processing accuracy shall be measured by dividing the weighted number of claims processed without any type of error by the total number of claims in the population.

   The Contractor shall track Member utilization across all participating pharmacy providers (retail, mail, and Specialty) and shall report Member utilization to the State at the State's request.

l. The POS system shall generate a claim pay status of pay or deny. The system shall allow a pharmacy to initiate a reversal (void) of a submitted claim. The telecommunications system supporting the POS function shall be available for claims submissions by pharmacies twenty-four (24) hours-a-day, seven (7) days-a-week (except for regularly scheduled and separately approved downtimes) and shall be accessible and operational no less than ninety-seven percent (97%) of this time. The Contractor shall not charge participating pharmacy providers any POS fees for services rendered under this contract. Network pharmacy providers are responsible for purchasing POS hardware, software and all telecommunications linkages. The Contractor shall require all participating network pharmacy providers to have the POS function. POS system used by contracted pharmacies to process pharmacy claims shall be accessible and operational ninety-nine point five percent (99.5%) of the time.

m. The Contractor shall apply a unique identification number to each claim and any supporting documentation. The Contractor shall use said identification number to recognize the claim for research or audit purposes. The Contractor shall ensure that all claims have been

processed to completion (e.g. approved or denied). The Contractor shall ensure that safeguards are in place to protect the confidentiality of Member information.

n. At the POS, the Contractor shall identify and deny claims that contain invalid provider numbers. Pharmacy providers shall submit claims and be identified by their individual and specific NPI. Prescribers shall be identified on all pharmacy claims by their specific NPI or DEA Numbers, or any other identifying number as required by the State or HIPAA.

o. The Contractor shall identify and deny Claims (unless specifically instructed differently by the State) that contain NDC or NDC-11 numbers including non-covered drug codes, LTE drug codes based on the Drug Efficacy Study Implementation ("DESI"), drug codes which are IRS to DESI Drugs and any terminated or obsolete drug codes. Such claims shall reject with situation specific messaging and error codes.

p. The Contractor's POS adjudication system must have the ability to reject claims when the Member's Plan coverage is secondary to another plan and notify Members and the Retail Pharmacy why the claim rejected. Secondary coverage claims must be submitted to the Contractor for possible reimbursement.

q. Upon conclusion of this Contract, or in the event of its termination or cancellation for any reason, the Contractor shall be responsible for the processing of all claims incurred for Members rendered during the period of this contract with no additional administrative cost to the State and according to the pharmaceutical price quoted for the year in which the pharmacy expense was incurred. The Contractor shall also be responsible for the payment of Rebates on all claims incurred prior to termination or cancellation. The claims run out period shall commence for a period of six (6) calendar months after the Contract term date, unless otherwise directed by the State.

r. The Contractor shall maintain a dedicated toll-free number to support system operations (Help Desk). The Help Desk shall be available twenty-four (24) hours a day, seven (7) days a week to respond to questions and problems from pharmacy providers regarding system operations and claims inquiries. The Contractor shall supply all the required information systems, telecommunications, and personnel to perform these operations. The Contractor's Help Desk and representatives/operators shall be located in the contiguous United States.

s. The Contractor shall process all of the State's claims on the same platform and shall not transition the State from the claims adjudication platform that they are implemented onto during the Term without prior approval In Writing by the State.

t. Contractor's own Mail Order Service pharmacy (if applicable), when processing Member claims shall provide Members a POS explanation of pharmacy benefits ("EOB"), which lists the individual Member's pharmaceutical out-of-pocket expenses, the Plan costs, and concurrently provides online any cost savings opportunities for the Member.

u. Payment card information processed on behalf of the State or for systems that support services provided by the State or on behalf of the State by the Contractor or approved sub-contractor shall be compliant with the current version of PCI DSS.

A.7. Claims Payment and Reconciliation

a. The Contractor shall adjudicate claims as payable only if said claims are (i) for Members (ii) for approved services (iii) dispensed by in-network pharmacy providers (or out-of-network providers, payable up to the MAC and minus any Member cost sharing) and (iv) and in accordance with the payment rules and other policies of the State. The State will only pay for approved and correctly Paid claims, not for rejected or reversed claims. Out of network claims shall be paid via direct Member reimbursement for (i) Members (ii) for approved services (iii) and in accordance with the payment rules and other policies of the State.

b. The Contractor shall pay the claim or advise the provider that a submitted claim is: (1) a Denied Claim (specifying all reasons for denial); or, (2) remains as a transaction that cannot be denied or allowed due to insufficient information and/or documentation (specifying all information and/or documentation that is needed from the provider in order to allow or deny the claim). An incomplete transaction may be resubmitted with the information necessary to complete the claim.

c. The Contractor shall pass directly to the Plan any contract terms negotiated with retail pharmacies (Discounts and Dispensing Fees) and pharmaceutical manufacturers (Rebates). Thus, the Contractor shall not receive any differential, or spread, between the pharmacy or manufacturer contracted rate and the Plan contracted rate. The Contractor shall provide a quarterly report to demonstrate the level of Pass-Through Transparent Pricing. The Contractor understands and agrees that this contract is deemed a '100% fully pass through, transparent contract' and agrees that the same costs charged to the Plan and Members, combined, are the same costs paid to network pharmacies. This will be audited on an annual basis by the State's benefits and actuarial consultants, in order to comply with Tenn. Code Ann. § 4-3-1021.

d. The Contractor shall be responsible for ensuring that any payments funded by or to the State are accurate and in compliance with the terms of this Contract, including items listed in Contract Attachment B; agreements between the Contractor and providers; and State and federal laws and regulations.

e. The Contractor shall ensure that every Paid Claim is attributed to one of the State's funding accounts; currently there are six (6) accounts. Any later adjustments of claims requested or initiated by either the State or by the Contractor shall be debited or credited to one of the State's funds and not to the funds that are paid to the Contractor in the way of Administrative Fees. Any adjustments or later claims processed that results in the State being owed money or the State owing money for a claim processed should be debited or credited against one of the State's funds and NOT against any Administrative Fees payments. Claims payment accuracy shall be ninety-eight percent (98%) or higher.

f. The Contractor shall notify the State within thirty (30) days of a retroactive termination of all claims paid on behalf of the affected Member during the period covering the retroactivity. The State will require the Contractor to assist the State in the recovery of claims.

g. The Contractor shall reimburse pharmacies for claims from their own funds and accounts. For the payment of all claims under this contract, the Contractor shall issue payments in the form of checks and/or Automated Clearing House ("ACH") electronic funds transfer against the Contractor's own bank account. The Contractor shall maintain security and quality controls over the design, printing, and mailing of checks, as well as any fraud prevention features of checks. Additional requirements related to payments are listed in Contract Section C.3. These claims paid by the Contractor will be reimbursed by the State's Office of Business and Finance (OBF) upon receiving sufficient documentation and reports from the Contractor to validate/justify the accuracy of the requested reimbursement for Paid Claims. The State will only reimburse the Contractor for Paid Claims. Claims that have been processed and adjudicated but not yet paid by the Contractor to pharmacies will not be reimbursed by the State.

h. The Contractor shall follow the State of Tennessee's law(s) surrounding prompt payment to providers. In the absence of a prompt payment law for PBMs, the Contractor shall pay providers for ninety-six percent (96%) of all Clean Claims within the lesser of fourteen (14) days or the contracted turnaround time with the pharmacy**.**

i. Tenn. Code Ann § 4-3-1021 requires the BA to compile and prepare a report each year prior to July 1 using data from various audit reports completed for us during the previous year. BA requires the participation and timely assistance of the Contractor to work with the actuaries and benefits analysts either in BA, under contract with the State, or the insurance committees to ensure that each report is completed timely. Tenn. Code Ann § 4-3-1021(5) requires a reconciliation of the PBM's payments to pharmacies with the State's reimbursement to the PBM.

j. Contractor's pharmacy payment process shall comply with any state prompt pay laws. In the absence of any prompt pay laws in Tennessee for PBMs, BA has chosen to use the following language regarding prompt payment of pharmacies: the lesser of thirty (30) days or the contracted turnaround time with the pharmacy. Payment reports provided to the State must assist the State in reconciling payment detail and recording accounting entries.

A.8. Pharmacy Network

a. The Contractor shall establish and maintain its broadest available national pharmacy provider network and a statewide any willing pharmacy provider network of retail, 90-Day-At-Retail, Mail Order Service, Specialty Pharmacies, and vaccine network administering pharmacies. These networks shall be adequate to provide covered pharmacy services and pharmacy location sites available and accessible in accordance with this contract and in compliance with Tenn. Code Ann § 56-7-2359.

b. The Contractor shall execute pharmacy provider agreements with any willing pharmacy providers for Retail, Mail Order Service, Specialty, and vaccine pharmacies that maintain all federal, state and local licenses, certifications, and permits, without restriction, required to provide pharmaceutical services and shall comply fully with all applicable laws and regulations.

c. The Contractor shall provide a list of the individual pharmacies (including at a minimum: name, NCPDP number, NPI, address, city, state, zip code, and telephone number) participating in the Retail, 90-day-At Retail, Mail Order Service, Specialty, and vaccine networks on the Contractor maintained splash page at least two (2) weeks prior to the State's annual enrollment period each year. The Contractor shall update these lists at least quarterly, and these lists shall appear in a prominent place on the contractor's splash page specific for the State's Members. Such list shall be easy to locate and utilize for all Members. The Contractor shall also include on the splash page a list of all drugs that have Quantity Limits, Prior Authorization requirements, and Step Therapy requirements. Those with quantity limits or morphine milligram equivalents (MME) per day limits should be listed by drug name and the thirty (30) day or ninety (90) day limit for each. Those with Step Therapy limits should list the drug that must be utilized prior.

d. The Contractor shall not require the State to mandate the use of Mail Order Service pharmacies or require Members to utilize one single pharmacy or a single chain or pharmacies for better pricing to the plan or lower Member cost share. Rather, the Contractor shall offer: (1.) a nationwide network of pharmacies for the thirty (30) network wherein Members may fill a prescription for their applicable thirty (30) cost share (Copayment or Coinsurance), (2.) a Mail Order Service pharmacy for ninety (90) prescription fills, (3.) a nationwide Retail Pharmacy network of pharmacies wherein Members can fill their ninety (90) prescriptions for the same cost share and the Plan would pay the same reimbursement rates for the medication as the Mail Order Service reimbursement rates (AWP minus x%), (4.) a statewide or nationwide network of Specialty pharmacies from which Members must choose a pharmacy to fill any Specialty Medication, and (5.) a statewide or nationwide network of pharmacies that include the ability to have a broad array of vaccines administered at the State-determined Copayment or Coinsurance (many of our vaccines are to be supplied at zero cost share).

e. Retail Network:

(1) The Contractor shall maintain a network of pharmacy providers to provide the covered services such that in urban areas, at least ninety percent (90%) of Members, on average, live within one and one half (1.5) miles of a Retail Pharmacy participating in the Contractor's network; in suburban areas, at least ninety percent (90%) of Members, on average, live within three (3) miles of a Retail Pharmacy participating in the Contractor's network; and in rural areas, at least ninety percent (90%) of Members, on average, live within ten (10) miles of a Retail Pharmacy participating in the Contractor's network. The Contractor shall justify and document all exceptions, which are subject to prior approval In Writing by the State. Contractor shall ensure that any pharmacy providing services will process and charge Members either their Plan Copayment or Coinsurance or the lesser-of (if the actual cost of the drug is less than the Member's adjudicated cost share). In no instance shall the Contractor enforce a gag clause restricting a pharmacist

from advising a Member of a less-cost drug or from collecting the less-of cost if it is lower than the Member's adjudicated cost share.

f. 90-Day-At-Retail Network:

(1) In accordance with any Willing Pharmacy Act, Tenn. Code Ann. § 56-7-2359, the Contractor shall allow any willing network retail pharmacies that agree with the Contractor's terms and conditions for Mail Order Service pharmacy to participate in a 90-Day-At-Retail network. The Contractor must create the 90-Day-At-Retail network for the Plan; Contractor must not under any circumstances attempt to direct Members to any pharmacy (either a specific Retail Pharmacy or the Contractor's Mail Order Service pharmacy). Neither the State nor the PBM may engage in any sort of influence as to which particular pharmacy a Member uses to fill a prescription, with the exception of Specialty Drugs referenced in Contract Section A.8.h (which the State requires be filled at a Specialty Network Pharmacy).

g. Mail Order Service Network:

(1) The Mail Order Service pharmacy shall possess sufficient staff and facilities capable of mailing ninety-five percent (95%) or more of all Member prescription orders filled from clean prescriptions not requiring pharmacy intervention within two (2) Business Days and ninety-nine and nine-tenths percent (99.9%) of all prescriptions mailed to eligible Members shall be dispensed with the correct drug strength, dosage form, prescription directions, and prescribing physician's name. The Mail Order Service pharmacy shall possess a current license to dispense controlled drugs (Schedule 2, 3, 4 and 5 substances).

(2) The Contractor's Mail Order Service pharmacy will not be required to dispense prescriptions for greater than a ninety (90) day supply of covered drugs, per prescription or refill, subject to the professional judgment of the dispensing pharmacist, limitations imposed on controlled substances (see Section 6 of Public Chapter 1039 of 2018), and manufacturer's recommendations. Exceptions to the ninety (90) day limit include medications that may be packaged by the drug manufacturer in quantities of just over 90 days and that do not lend themselves to being split by the pharmacist (e.g. insulins); in those instances, the Mail Order Service pharmacy may fill using the packaging as is and charge a ninety (90) day Copayment to the Member. Prescriptions may be refilled providing the prescription states that refills remain. All prescriptions will be filled in accordance with Tennessee laws and regulations.

(3) The Contractor shall guarantee that MAC pricing will apply at mail for Generic Drug medications. Contractor shall guarantee that a Generic Drug medication will never cost more at mail than at a Retail Pharmacy.

(4) The Contractor shall guarantee that the AWP applied to Mail Order Service claims must be the actual NDC or NDC-11 of the package size dispensed.

(5) The PBM Mail Order Service shall inform the Member, the prescriber, and the State if it substitutes products that will result in a Member Copayment or plan cost that is greater than the Copayment or plan cost that would have been incurred had the prescription been dispensed as written. The Contractor shall only engage in such substitutions when there are widespread marketplace drug availability issues with the more cost effective product, if there is a Member safety issue or if there is a drug interaction or efficacy issue – and only with prescriber approval, if applicable.

(6) The Mail Order Service pharmacy shall communicate to the Member, by phone, e-mail or text, any delays, beyond three (3) Business Days, in delivery of prescriptions. Members shall be notified of such delays within twenty-four (24) hours of the discovery of the delay.

(7) The Mail Order Service pharmacy shall provide Members refunds for monies owed back to them instead of maintaining credits at the mail facility.

(8) The State will not pay any outstanding balances owed by Members to the Contractor or its network pharmacy providers.

(9) The Contractor shall obtain open refill files from the State's current Mail Order Service contractor.

(10) The Contractor shall maintain a secure website supporting the Mail Order Service function, which allows Members to access their pharmacy claims and request and pay for refills online. Said website shall be operational no later than thirty (30) days prior to the go-live date.

h. Specialty Network:

(1) The Specialty Pharmacy network shall be the preferred pharmacy provider of certain drugs. The Specialty Pharmacy network shall guarantee more favorable reimbursement rates than the Retail, Mail Order Service and 90-day At Retail networks on the designated products, in the aggregate, and possess unique clinical monitoring, Member assistance, and distribution capabilities.

(2) The Contractor, or other third-party Specialty Pharmacy that has contracted with the Contractor, may provide Specialty Drugs. The Contractor shall add new Specialty products and the pricing for these products to the list of Specialty Drugs.

(3) Unless otherwise directed by the State, all drugs placed on the Contractor's Specialty Drug list shall meet the definition of Specialty Drugs in Contract Section A.2. The drug must meet at least two of the first four criteria (a thru d) and the final criteria (e).

(4) Unless otherwise directed by the State, the Contractor shall limit Specialty Drugs to no more than a thirty (30) day supply, which it shall provide exclusively via Specialty network pharmacies. The Contractor must solicit pharmacies inside the State of Tennessee to join their Specialty Pharmacy network, per the any willing provider law codified at Tenn. Code Ann § 56-7-2359 (even if the Contractor operates its own Specialty Pharmacy). Neither the Contractor nor the Contractor's staff shall attempt to steer Members to utilize any particular pharmacy within the Specialty Pharmacy Network, so long as Members do utilize a pharmacy in said network for their Specialty Medications.

(5) Contractor understands that the sole Administrative Fee (PMPM) and any Clinical Fee (if applicable) paid to the Contractor monthly constitutes all services payable under this Contract, including Specialty Drug management (Step Therapy, first fill counseling, recalls, Member adherence education, Prior Authorization, and similar industry standard PBM activities that relate to Specialty Drug management.)

(6) The Contractor shall guarantee that the AWP applied to Specialty claims will be the actual NDC or NDC-11 of the package size dispensed.

(7) In addition to the Contractor's own requirements for pharmacy participation in the Specialty Pharmacy Network, the State imposes the following requirements:

State Specialty Network Participation Criteria

a) Storage, Shipping & Handling: Pharmacy must have the ability to properly store, handle and ship (if offered) medications per the product labeling.

b) Registration and Licensure: Pharmacy must be registered/licensed and in good standing with the Board of Pharmacy in the state in which it is located and in Tennessee, if located out of state.

c) Member Counseling & Clinical Monitoring: Pharmacy must have a licensed pharmacist on staff to assist with, and counsel Members on issues common to Specialty Medications. Such issues include identification and management of potential side effects, appropriate use of the medication and the importance of medication adherence.

d) Member Notification of Recalls: In the event of any product recalls, the Pharmacy will identify and notify affected Members.

(8) The Contractor shall notify affected Members by letter within fifteen (15) days after any Specialty Network Pharmacy drops out or leaves the Specialty Pharmacy Network. Upon notification that any Specialty Pharmacy is leaving the Specialty Pharmacy Network, the Contractor shall determine if any Members have utilized said pharmacy within the previous ninety (90) days and mail these Members a notification letter that the pharmacy is leaving the network on a specific date and also include with the letter a printed list of remaining contracted Specialty Network Pharmacies. The State has the right to review any such letter and make appropriate edits prior to approval

and mailing. In addition, the Contractor must notify the State's Director of Pharmacy Services In Writing within five (5) Business Days any time a Specialty Pharmacy leaves the Specialty Pharmacy Network.

i. The Contractor shall Lock In Members who meet the Contractor's Lock In guidelines into just one network pharmacy and one prescriber. The Contractor's Lock In guidelines shall be provided to the State for approval during plan implementation.

j. The Contractor shall routinely monitor Member prescription drug fill habits for potential pharmacy shopping of narcotics and other addictive type medications as well as prescribing habits of physicians to review for possible doctor shopping by Members for these type medications. When the Contractor deems that prescribing or fill habits by Members or physicians are outside the norm, the Contractor shall initiate contact with physician and/or all other prescribers in the Member's profile history to determine the diagnosis and/or need to such medications. When the Contractor's clinical pharmacist deems it in order for a Member to be Locked Into a single pharmacy in order to restrict fill habits, he or she should initiate contact with State to initiate such a Lock In.

k. The Contractor shall annually provide the State with a GeoNetworks®, Quest, or comparable report showing service and geographic access for the retail network and the 90-Day-At-Retail. The State will review the pharmacy network structure and shall inform the Contractor In Writing of any deficiencies. The Contractor shall develop a plan of action, approved by the State, to correct said deficiencies within sixty (60) days from the date the Contractor was first notified of the problem.

l. The Contractor shall generate and deliver to the State, within five (5) working days of the end of each quarter, a Quarterly Network Changes Report. This report shall include all additions to the network and all pharmacies no longer participating in the network.

m. The Contractor shall develop a nationwide Vaccine Network of pharmacies where Members may receive covered plan vaccinations including, but not limited to, influenza, shingles, hepatitis, measles, mumps, and rubella ("MMR"), tetanus, pertussis, and measles.

n. If any pharmacy chain with greater than or equal to five hundred (500) pharmacies OR who has filled prescriptions for greater than or equal to 10,000 Members within the previous twelve (12) months leaves Contractor's network or notifies Contractor of plans to leave the network, the Contractor shall immediately notify the State as well as draft Member notification letters for mailing to affected Members at the Contractor's cost. Letters should be mailed at least thirty (30) calendar days before the effective date the pharmacy intends to leave the network. State must approve notification letters before they are mailed.

A.9. Formulary Management

a. The Contractor shall design, develop, implement, administer and maintain the Formulary in compliance with coverage defined in the Plan Documents by the deadline listed in Contract

Section A.30. The Formulary shall include FDA approved drugs that have been evaluated for inclusion by the Contractor's P&T Committee. The Contractor shall be the exclusive Formulary administrator for the prescription drug benefit. .

b. By go-live date the Contractor shall assume responsibility for administering and maintaining the Formulary, including the PA criteria and clinical programs.

c. The Contractor shall implement the Formulary within five (5) working days after receipt of the State's approval In Writing. The Contractor shall allow Formulary customizations at the State's request at no additional cost to the State, including the ability to add over-the-counter ("OTC") products. The Contractor shall implement customized formularies within an acceptable timeframe proposed by the Contractor and approved by the State In Writing.

d. The Contractor shall monitor Formulary compliance, report compliance information to the State quarterly, and provide suggestions for improving Formulary compliance.

e. The Contractor shall implement changes to the Formulary, Step Therapy, PA and other clinical edit requirements within thirty (30) Business Days of the State's approval or request. Additional time, beyond thirty (30) Business Days, may be granted with the State's prior approval In Writing. Changes shall include modifications to the POS system and all supporting systems and documents. The Contractor shall notify pharmacy providers and affected Members In Writing at least thirty (30) days prior to the implementation, unless the State requests a shorter notification time. The State must provide prior approval In Writing for all pharmacy provider and Member notifications.

f. The Contractor shall not implement or administer any program that results in the therapeutic switching of Members from lower net cost products to higher net cost products. The only exceptions are for Member safety or efficacy issues or, upon notification to the State and with prescriber approval, in response to widespread marketplace drug availability issues with the more cost effective product.

g. Final decisions for inclusion or exclusion from the Formulary shall be at the sole discretion of the State. At the time of Contract implementation, the State only excludes fertility medications from coverage; however, the State reserves the right to add to or amend this coverage in the future.

h. The Contractor shall regularly review the State's three (3) Plan Documents for the State, Local Education, and Local Government Plans to ensure compliance with providing medications and supplies as noted or excluded in these documents. The Contractor must ensure compliance with this and other similar language in the Plan documents throughout the term of this contract.

i. Upon request by the State, the Contractor will work with State staff to reduce the use of coupons or drug cards utilized at retail pharmacies to keep these from artificially contributing to a Member's maximum out of pocket costs or deductibles.

j. Formulary Design and Development:

(1) Based on the recommendations by the Contractor's P&T Committee, the Contractor shall design the Formulary to (i) maximize the prescribing and dispensing of safe and clinically effective drugs within each therapeutic class that are the most clinically effective as well as the most cost-effective (ii) ensure that the more costly drugs, which do not have any significant clinical or therapeutic advantage over others in their class, are used only when medically necessary; have a higher Formulary tier; (in certain instances, these drugs may be excluded from the Formulary) and (iii) ensure that ninety-five percent (95%) or more of Mail Order Service prescriptions and ninety percent (90%) or more of retail prescriptions for MS drugs will be dispensed with a Generic Drug product.

(2) The Contractor's P&T Formulary review process shall be an evidence-based review of clinical guidelines and medical literature to identify which agents and classes of drugs shall be included on the Formulary. Within the classes of drugs determined to be included on the Formulary, the Contractor shall determine which drugs within each class are safe, clinically effective, cost rational and provide equivalent clinical outcomes. The Committee's recommendations for inclusion on the Formulary shall be based on a thorough review of clinical effectiveness, safety, and health outcomes, followed by an analysis of the relative costs of the drugs in each class under consideration. The Contractor shall, at the State's request, provide the State documentation describing the Formulary review process, logic and methodology utilized by the Contractor's P&T Committee.

(3) The Contractor shall identify therapeutic alternatives and opportunities for savings and report these opportunities at the quarterly review meetings with the State. The Contractor shall also present recommendations at the quarterly review meetings concerning therapeutic categories that should be avoided with regard to inclusion on the Formulary, if applicable.

(4) The Contractor may modify drugs included on the Formulary as a result of factors including, but not limited to, medical appropriateness, manufacturer Rebate arrangements, and patent expirations. The Contractor shall notify the State of modifications to the Formulary, which will include a statement as to the reason for the modification. In the event that one of the top twenty (20) drugs (by prescription volume) utilized by eligible Members is being removed, the Contractor shall provide a more detailed analysis justifying the proposed removal of the drug from the Formulary including financial analysis, Member disruption analysis and Member and pharmacy provider communication strategy.

(5) Upon review and approval by the State, the Contractor shall implement Formulary management programs, which may include cost containment initiatives, such as therapeutic interchange programs; communications with eligible Members, participating pharmacies and/or physicians (including communications regarding Generic Drug substitution programs); and financial incentives to participating pharmacies for their participation.

(6) The Contractor shall design, develop, implement, administer and maintain a listing of quantity limits for certain preferred and non-preferred drugs. The Contractor shall base this list on therapeutic best practices (current clinical guidelines) or opportunities to reduce the cost of the most appropriate dosage form. The Contractor shall include drugs and quantities on the quantity limits listing in the Formulary documents and shall code these limits and pharmacy messaging into the POS system.

(7) The Contractor shall ensure the Formulary is readily available on the Internet for both prescribers and Members and that prescribers and Members can easily identify utilization restrictions, or Formulary alternatives for non-Formulary or high-cost products.

(8) The Contractor shall coordinate its Formulary development process and criteria with the Contractor's clinical program requirements (PA, Step Therapy, etc.) to ensure consistent processes and minimize Member or prescriber impact.

(9) The Contractor shall ensure that the pharmacy program and POS system include provisions for the dispensing of an emergency supply (early refill, Member lost prescription, vacation supply, dose increase, etc.), as described and determined by the Plan Document.

(10) The Contractor shall supply to the State a Specialty Drug List Additions and Deletions Report which lists any specialty drugs and each drug's specialty classification that have been added or deleted during the previous calendar quarter, as noted in Contract Attachment C.

A.10 Benefit Coverage/Plan Design

a. The Contractor shall support and administer the pharmacy benefit structure developed by the State, which may include the following:

(1) Any updated benefit Plan design;

(2) Copayments/Coinsurance at retail, 90-Day-At-Retail , Mail Order Service and Specialty;

(3) Mixed Copayments at retail and Mail Order Service (fixed dollar + %);

(4) Minimum/Maximum amounts with Coinsurance;

(5) Annual Out-Of-Pocket maximums per person and per family;

(6) Out-Of-Pocket maximum per Rx;

(7) Deductibles on brand name drugs only;

(8) Deductibles based on network;

(9) Therapeutic Class "Maximum Allowable Charges";

(10) Therapeutic Copayments/Coinsurance for specific drug classes such as asthma and diabetes;

(11) Copayments/Coinsurance based on previous drug trials (e.g., higher co-pay if claims history does not include trial of first-line/preferred drug/drug class);

(12) Copayments/Coinsurance based on place of service (e.g., incentives to use preferred retail pharmacies, Specialty pharmacies, etc.);

(13) Copayments/Coinsurance dependent on Member's behavior (e.g. enrollment or stratification level in a disease management program); and

(14) Copayments/Coinsurance on the days supplied (e.g., a mail claim processed for a thirty (30) day supply).

(15) Following requirements of the PPACA, provide for various coverages and benefit exceptions (Note that this is not an all-inclusive list; rather, it is a summary of *examples* to be followed and implemented):

i. Aspirin: zero Copayment for ages >= 45, Generic Drug only, OTC requires prescription

ii. Iron Supplements: ages 0-1; no PA; no quantity limits; brand, Generic Drug, and OTC requires prescription;

iii. Oral Fluorides: ages 0-6; no PA; no quantity limits; brand, Generic Drug, and OTC requires prescription

iv. Folic Acid: Females 0-55 only; no PA; quantity limit of 100 units per fill; Generic Drug only; OTC requires prescription

v. Tobacco Cessation: zero Copayment; limit of 2, 12 week courses of treatment (168 days); cover smoking cessation medications, and nicotine replacement products such as patches, gum, and lozenges (inhaler not covered), Rx or OTC requires prescription

vi. Immunizations at zero Copayment – “A” and “B” rated recommendations by the USPSTF.

vii. Vitamin D – both genders, ages >=65; brand and Generic Drug, no PA, OTC requires prescription

viii. Oral Contraceptives, emergency contraceptives, injectables; zero Copayment, Generic Drug only and Single-Source brands; no PA; requires prescription.

ix. Low dose Generic Drug statins (PBM determines which NDC or NDC-11) process and pay at zero Copayment

b. At the State’s request, the Contactor shall implement value-based payments on medications where provider payments are differentiated based on quality, efficacy, and/or patient outcomes (or any combination of these). The Contractor shall not implement such value oriented payments to pharmacies or manufacturers without prior approval In Writing from the State. Upon implementation of any value-based payments, the Contractor shall report descriptive information and data about its value oriented payments in sufficient detail to enable the State to adequately monitor the Contractor’s payments. The information that may be requested may include the following:

- The drug name(s), NDC, and full GPI;
- Drug manufacturer name;
- The total number of prescriptions filled;
- The total number of members filling a prescription for each drug;

- The projected financial impact and savings to the plan as a result of the program.

c. Each fall, no later than November 1, the Contractor shall provide to the State various test results documents of the following plan year's benefits set-up in the Contractor's claims adjudication platform broken down by generics, preferred brands, non-preferred brands, specialty drugs and by 30 (thirty) and 90 (ninety) day supplies. Such test results documents shall also provide State staff with the applicable deductibles and maximum out of pocket amounts by coverage level offered by the State. This exercise is to ensure proper benefit design set up for all health plan options.

A.11. PPACA

The Contractor will be responsible for ensuring that all pharmaceutical benefits and programs offered by the State and administered by the Contractor meet all current and future requirements of PPACA and shall advise the State on all such benefits and programs, including benefit design, Formulary design and management, Copayment and/or Coinsurance structure, appeals of all levels, and any and all associated costs.

A.12. Clinical Programs

a. The Contractor shall utilize prescription drug claims data to enhance:
   (1) DUR;
   (2) Clinical management initiatives;
   (3) Therapeutic management initiatives; and
   (4) Gaps in care analysis

b. The Contractor's clinical program offering shall at a minimum include:
   (1) An evidenced-based approach;
   (2) Compliance (poor adherence);
   (3) Utilization management programs;
   (4) Information available via the web;
   (5) Outcomes data (savings and Member impact); and
   (6) Custom programs based on the State's specific utilization

At the request of the State, the Contractor shall provide additional clinical program offerings.

c. The Contractor shall provide clinical, utilization management programs specific for Specialty Drugs/self-administered injectable medications. A clinician shall be available, through the Specialty Pharmacy network, to patients taking Specialty Medications twenty-four (24) hours a day, seven (7) days a week.

d. The Contractor shall provide a therapeutic substitution and Generic Drug dispensing program with provisions for written, phone, and/or face-to-face contact with prescribing physicians and Members in order to advise them of the potential savings resulting from substituting a costlier drug with a lower cost medically appropriate alternative drug. The Contractor shall report results of the program to the State on an annual basis. The

Contractor shall receive prior approval In Writing from the State to implementing Member-targeted activities.

e. The Contractor shall maintain a Generic Drug dispensing rate ("GDR") of 85.0% or higher.

f. The Contractor shall only communicate with Members about pharmacotherapy alternatives or alternative places of service when a change will save both the Member and State monies (net of Copayments).

g. Step Therapy:

(1) The Contractor shall administer and maintain a Step Therapy program that promotes the use of the most cost-effective drug therapy for a specific indication, regardless of drug class.

(2) At the State's request, the Contractor shall implement a Step Therapy program, targeting all brands, for the following drug classes: Proton Pump Inhibitor's (PPIs), Angiotensin II Receptor Blockers (ARBs), Angiotensin-Converting Enzyme (ACE) Inhibitors, Cholesterol lowering medications, Antidepressants, Anti-hyperlipidemics, Pain (Rheumatoid Arthritis/Osteoarthritis), Anti-asthmatics, and Narcotic and central analgesics. At the State's request, additional drug classes may be targeted for Step Therapy at any time and shall be implemented by the Contractor at no cost to the State.

(3) As the Formulary is re-evaluated and/or expanded, the Contractor shall develop proposed Step Therapy criteria for non-preferred drugs and certain preferred drugs and present those criteria to the State for review and input. The Contractor shall base these recommendations on therapeutic best practices and drive utilization to the most cost effective agents or classes.

(4) The Contractor shall describe the drugs and the criteria included in the Step Therapy program on all Formulary documents. The Contractor shall code these criteria into the POS system such that the system shall have an edit on all drugs in the target classes that pharmacy providers submit for dispensing. Before the new drug may gain approval through a PA, the Contractor shall review the claims history of prior use of a more cost-effective drug and approve the PA only if such evidence is present.

h. Prior Authorization ("PA"):

(1) The Contractor shall disclose and share, In Writing, all PA criteria and procedures and decision trees to the State during plan implementation or at any time during the Term for any brand or Generic Drug medication, or any other medication covered as part of the Plan benefits offered through Contractor, if requested by the State.

(2) The Contractor's POS system shall determine whether a prescribed drug requires PA and if so, ensure that the Member received the necessary approval prior to authorizing the transaction and permitting reimbursement. All PA services shall be provided at no additional cost to the State.

(3) By the go-live date the Contractor shall offer to prescribing physicians an online PA portal whereby the physician can go online to initiate a PA request via secure medium. Providing this information strictly via telephone or customer service record ("CSR") does not exempt the Contractor from this requirement.

(4) The Contractor shall ensure that PA staff evaluates ninety-nine percent (99%) of PA requests and notifies the prescribing physician within twenty-four (24) hours, In Writing. The Contractor shall implement an agreed upon set of edits and PA criteria on the go-live date. Additional PA edits may be implemented at the State's direction at any point without additional cost to the State.

(5) The Contractor shall submit a quarterly PA report, which includes PA statistics including, but not limited to, the number of PAs submitted, the number approved and denied and the purpose of the PA (clinical edit, emergency override, etc.).

(6) The State, or its qualified auditor selected in the sole opinion of the State, shall have the ability at any time to do clinical auditing of Specialty claims approved by the Contractor for filling and payment. The State, or its qualified auditor, will be auditing to verify that the Contractor is following its own rules and not merely providing a verbal attestation or calling clinical staff and the prescriber's office and walking them through a series of "yes" or "no" questions to merely get to a "yes" for approval. Evidence based PA criteria are needed and must be adhered to when approving Specialty Drug claims for filling and payment.

(7) The Contractor shall not provide a PA override which, in effect, freezes a Member into a set, specific Copayment or Coinsurance amount in perpetuity. Any and all drugs are always subject to the then-in-effect Copayment or Coinsurance for a particular plan year.

i. The State has the ability to "opt-out" of any clinical program.

j. Prior to implementing any program or service for which the Contractor receives external funding, the Contractor shall disclose the details of such program and such sources of external funding to the State. The State shall have the authority to opt-out of any such program that the State determines is not in the best interest of its Members.

k. At the State's request, the Contractor shall support the State's efforts to develop a MTM program. Such assistance shall include providing requested Member pharmacy data, communicating with and educating participating network pharmacies, and assisting in the identification of Members who should receive MTM services.

l. At the State's request, the Contractor shall implement an opioid management program that is no less strict than the current CDC-recommendations https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf (with PA requests that may allow a higher MME per day, as approved by the State, if appropriately documented by a provider). Any program targeting opioids or opioid management must comport with Tennessee law at all times during the Term.

m. Manufacturer Drug coupons cannot be considered revenue and do not count toward Rebates or Rebate guarantees in the calculation and reconciliation of those.

n. The Contractor shall provide case management services to plan participants who fill Specialty Medications through the Contractor's own Specialty pharmacy. This shall include identifying and outreaching to Members with conditions such as cancer, rheumatoid arthritis, Hepatitis C, Multiple Sclerosis, and Hemophilia (conditions listed here are examples only and not an all-inclusive list). Registered pharmacists shall work with the member, health care providers, primary caregivers and the state's contracted medical vendors to coordinate the most appropriate, cost-effective site of care and place-of-fill for Specialty Medications.

A.13. Prospective/Concurrent DUR

a. The Contractor shall furnish a fully automated prospective/concurrent DUR system that meets all applicable state and federal requirements. The DUR function shall meet minimum federal DUR regulations as well as the additional specifications in Contract Sections A.12 and A.13 and be flexible enough to accommodate any future edit changes required by the State. The Contractor shall recommend to the State, annually at review meetings, new DUR edits that improve quality and reduce pharmacy program costs.

b. Prior to authorizing claims and permitting reimbursement, the Contractor's system shall provide DUR services that apply State-approved edits to all claims. The edits shall provide clinically appropriate information described in Contract Section A.13.c to the dispensing pharmacist.

c. The Contractor's POS system shall apply the results of DUR processing in the claim adjudication process. Claims that reject as a result of DUR processing shall include situation specific messaging and error codes that enable the pharmacy provider to take appropriate actions. The Contractor may use an existing DUR package which meets all applicable state and federal requirements. The Contractor's system shall include the following minimum DUR features at installation:

(1) Potential Drug Problems Identification - The Contractor's system shall perform automated DUR functions. The system shall automatically identify and report issues to the pharmacy provider including, but not limited to:

i. Problems that involve potential drug overutilization;

ii. Problems that involve therapeutic duplication of drugs when the submitted claim is associated with other drugs or historical claims identified for a given Member;

iii. Problems that involve drug use contraindicated by age, gender and presumed diagnosis codes on historical claims for a given Member;

iv. Problems that involve drug use contraindicated by other drugs on current or historical claims for a given Member (drug-to-drug interactions);

v. The level of severity of drug-to-drug interactions;

vi. Potentially incorrect drug dosages or a change to the quantity per prescription to ensure the most cost-effective strength is dispensed;

vii. Potentially incorrect drug treatments;

viii. Potential drug abuse and/or misuse based on a given Member's prior use of the same or related drugs; and

ix. Early refill conditions and provide, at the drug code level, the ability to deny these claims. The Contractor shall customize refill-too-soon edits.

(2) POS Pharmacy Provider Cancel or Override Response to DUR Messages – Prior to the final submission of POS pharmacy claims, the Contractor's system shall automatically generate DUR messages in a manner that shall enable a pharmacy provider to cancel submission of the claim or to submit it if it is a message that can be overridden by the pharmacy.

(3) Flexible Parameters for Generation of DUR Messages - The Contractor's system shall have the ability to transmit new or revised DUR messages and to define the DUR criteria that activate these messages.

(4) DUR Member Profile Records - The Contractor's system shall provide and maintain Member profiles for DUR processing of submitted claims. The Contractor shall base Member profiles on presumed diagnoses from pharmacy claims and other data available.

(5) Disease/Drug Therapy Issues Screening - The DUR system shall have the capability to screen for drug therapy concerns by specific drugs relative to high-risk diseases, to include but not limited to: cardiovascular disease; diabetes; psychiatric disease; and respiratory disease.

(6) Patient Counseling Support - The Contractor's system shall present DUR results to pharmacy providers in a format that supports the ability to advise and counsel Members appropriately.

A.14. Retrospective DUR (Retro-DUR)

a. The Contractor shall provide a Retro-DUR program supported by licensed clinical pharmacists. The Contractor shall develop, maintain and update a set of evidence-based clinical criteria, which the Contractor shall use to detect potential problems such as poly-pharmacy and related over-utilization, underutilization, drug-to-drug interactions, therapeutic duplications, incorrect drug dosage and duration of treatment, possible fraud and abuse issues, and other instances of inappropriate drug therapy as may also be related to a Member's age or disease state. The Contractor's Retro-DUR system shall:

(1) Provide provider practice analyses that includes identification of key performance indicators such as Generic Drug dispensing rate, controlled substances, Formulary compliance, etc.;

(2) Trend providers' prescribing habits and identify those who practice outside of their peers' norm;

(3) Identify patients who may be abusing resources through poly-pharmacy utilization patterns or visiting multiple providers;

(4) Identify patients with excessive use of controlled substances or other highly abused medications;

(5) Produce reports that detail patient and prescriber trends and that identify potential quality of care problems and/or potential fraud and abuse; and

(6) Have in place an intervention process and a system for tracking prescriber response to the interventions.

b. The Contractor shall utilize the evidence-based clinical criteria to conduct quarterly prescriber and Member profile reviews. The Contractor shall set the number of Member and prescriber profile reviews, with approval In Writing by the State, to be conducted at the quarterly review meeting. The Contractor will notify the State In Writing of the focus of, and methodology to be used in, the profile reviews at least thirty (30) days prior to the initial review start date.

c. The Contractor shall complete quarterly prescriber and Member profile reviews and distribute results/interventions, as recommended by the clinical pharmacist, to prescribers within ninety (90) days of the end of the quarter. The Contractor shall implement interventions designed to address problems identified during profile reviews. These interventions may include mailings, phone calls, faxes, or face-to-face visits. Other interactions may occur after receiving approval from the State. Mailings shall consist of an intervention letter to the prescriber and/or pharmacy provider detailing the reason for the letter, the purpose of the intervention and providing educational information. Member profile(s) illustrating the potential problem and suggesting corrective action may also be included. The State will approve any summaries, correspondence or other documents produced as a result of the review process prior to their distribution.

d. The Contractor shall maintain a system capable of tracking all interventions and determining cost savings related to the specific interventions.

e. DUR and Retro-DUR Reporting

(1) The Contractor shall have a qualified DUR clinical pharmacist, designated to the Plan, prepare presentations and attend meetings with the State to present DUR and Retro-DUR data, findings, utilization, and recommendations for improvement. Such presentations shall occur up to four (4) times annually, as requested by the State. The Contractor shall present, at a minimum, the following reports/information for each of the State sponsored plans, which shall convey rolling twelve (12) month trends:

i. Utilizing-Members data;

ii. Utilization by age demographics;

iii. Utilization by top twenty (20) therapeutic classes determined both by number of claims and by payment amount;

iv. Top twenty (20) drugs as ranked by claim count and by total payment;

v. DUR data including totals of DUR messages sent and savings associated with the top twenty (20) drugs associated with each DUR edit;

vi. Retro-DUR reviews, summary of the interventions and estimated cost savings information as associated with both Member and provider profile review and interventions;

vii. Distribution of Clinical Alerts as prepared monthly by the Contractor's Clinical Management staff; and

viii. Any additional reports included in the Contractor's standard DUR reporting package.

(2) The Contractor shall report quarterly the outcomes of the Retro-DUR initiatives. The Contractor's system shall track the impact of DUR initiatives by comparing specified data elements pre- and post-intervention. At the State's request, the data elements tracked will vary according to the focus of study and/or type of intervention employed and may include, but shall not be limited to:

a. Drug change within a sixty (60) or ninety (90) day period of the intervention, or within another time period as otherwise directed by the State;

b. Total number of drugs pre and post intervention;

c. Change in dose/dosing frequency of medication within a sixty (60) or ninety (90) day period of intervention or within another time period as otherwise directed by the State;

d. Daily dose of drug in question pre and post intervention;

e. Assessment of various interactions (as relevant to the activity) pre- and post-intervention which may include drug-to-drug interactions (e.g., number of drugs identified and severity index), pregnancy interactions, disease state interactions, therapeutic duplications, allergy interactions, and age-related medication problems;

f. Compliance with national guidelines (e.g. percentage of patients with CHF on beta-blocker, diuretic, etc.) depending on the disease state targeted by the Retro-DUR initiative;

g. Generic Drug medication utilization;

h. Emergency supply frequency;

i. Formulary compliance; and

j. Patient adherence as defined by medication possession ratio.

A.15. Financials

a. Other than those addressed in this Contract, the Contractor shall not collect any additional fees, Rebates, premiums, or revenue from the State of Tennessee.

b. Ingredient Cost:

(1) The Contractor shall guarantee the AWP used to price claims will be the one associated with the actual NDC or NDC-11 for the product on the date dispensed and the actual package size from which the product was dispensed at a participating pharmacy, Mail Order Service pharmacy, and Specialty Pharmacy. The Contractor shall communicate any exceptions to this rule (e.g., Compound Prescriptions, etc.) to the State In Writing and such exceptions are subject to approval by the State.

(2) If using various sources to price claims, the Contractor shall use the AWP that provides the lowest price available.

(3) The Contractor shall guarantee that in the event there are changes in the marketplace to the baseline measure used for the Ingredient Costs of drugs (e.g. AWP) the Contractor shall adjust accordingly to provide an equivalent price. The Contractor shall provide notice to the State and the conversion shall be agreed upon In Writing before any changes are made.

In the event of substantial changes in the marketplace that are outside of the Contractor's control which impact the pricing components of this agreement, the Contractor may request approval from the State to make adjustments to their pricing and guarantees. Such adjustments must be prior-approved In Writing by the State and must result in cost neutrality or cost savings to the State, as compared to the terms that were in place prior to the adjustments going into effect. The Contractor must provide the State and/or its consulting actuary adequate information to analyze the request and its impact prior to its implementation. The State may deny any such requests and all decisions of the State are final.

(4) The Contractor shall apply a MAC-list at Mail Order Service pharmacies and at 90-Day-At-Retail network pharmacies for Generic Drug medications. The list will have prices equivalent to or lower than the MAC-list applied to retail claims and effective MAC Discounts cannot be lower than effective non-MAC AWP Discounts. The Contractor shall use the same MAC List for network pharmacies (retail, Specialty and Mail Order Service Service) and the State and shall, upon State request, provide the most current MAC List to the State on a quarterly basis in a spreadsheet format. The Contractor will employ its most aggressive MAC List which must include a minimum of ninety-five percent (95%) of all Generic Drugs. In addition, the MAC pricing schedule at Mail Order Service (including Specialty) will include the same or more favorable pricing (lower per unit prices) than at retail for every drug. The Contractor's MAC pricing schedule at Mail Order Service will include a comparable list of low cost Generic Drugs included in retail Generic Drug programs at competitive pricing such that members moving from the Retail Channel to the Mail Channel will NOT be materially impacted with an increase in costs.

(5) The Contractor shall utilize a brand/Generic Drug indicator based on data elements available from only one nationally recognized source such as Medi-Span, etc. unless a change in the indicator will lower the price for the State or the State agrees that the change is acceptable.

(6) The Contractor shall guarantee that actual reimbursement rate, in the aggregate, to network pharmacies for pharmaceuticals will not exceed the guaranteed Discount off AWP, plus the negotiated Dispensing Fee.

(7) The Contractor shall apply 'lowest-of-pricing' logic at retail, Mail Order Service, 90-Day-At-Retail, and Specialty Pharmacies, which means that the plan and plan Members will pay the lesser of (i) Copayment/Coinsurance, (ii) contracted rate or AWP, or MAC, if available), plus Dispensing Fee or (iii) U & C. In no event will the Member or plan cost

share be greater than the contracted cost. The State will not be billed for any Zero Balance Due claims.

(8) The Contractor shall not charge a minimum Copayment/Coinsurance for any Mail Order Service, Retail, 90-Day-At-Retail, or Specialty Pharmacy claims.

(9) The Contractor shall guarantee that the terms offered for Mail Order Service claims shall not vary based on the days' supply (claims processed for less than a ninety (90)-day supply).

(10) The Contractor shall provide, during the first quarter of each calendar year, an annual reconciliation between the average network Discounts achieved and the guaranteed average Discount amounts for retail, 90-Day-At-Retail, Mail Order Service and Specialty for the previous calendar year. The Contractor will pay one hundred percent (100%) of any Discount guarantee shortfall to the State within forty-five (45) days of the close of each annual reconciliation period (with the State retaining one hundred percent (100%) of any savings above the guarantees). Further, should the Contractor miss the annual retail Generic Drug Discount guarantee by at least two (2) percentage points, the State will receive one hundred percent (100%) of the shortfall plus an additional payment of ten percent (10%) of the shortfall amount (Under-performance payment). The Contractor will not be able to offset or recoup any Under-performance Payment in any reconciliation. Specialty reconciliation will be on Brand only. Generic specialty will be calculated as retail Generic.

c. Dispensing Fees

(1) The Contractor shall provide, during the first quarter of each calendar year, an annual reconciliation between the Dispensing Fees paid and the guaranteed maximum average Dispensing Fee amount for the previous calendar year. The Contractor will pay the State one hundred percent (100%) of any shortfall for each guarantee within forty-five (45) calendar days from the close of each annual reconciliation period (with the State retaining one hundred percent (100%) of any additional savings achieved above each minimum guarantee). Specialty reconciliation will be on Brand only. Generic specialty will be calculated as retail Generic.

(2) The Contractor shall adhere to the additional requirements related to Dispensing Fees listed in Contract Section C.3.

d. The Contractor shall adhere to rate guarantee requirements listed in contract Section C.3.

A.16. Pharmacy Rebates

a. The Contractor shall adhere to the additional requirements related to pharmacy Rebates listed in Contract Section C.3.

b. The State, or its contracted benefits consultant and actuarial consulting firm, will audit the Rebates that are accrued and paid to the State. Contractor shall pass all Rebates through to the Plan. Rebates shall be one hundred percent (100%) auditable to the NDC or NDC-11 level. The Contractor shall provide, with each pharmacy Rebate check presented to the State, a report showing the amount of the check broken down by the groups that comprise the total check amount, as well as the calendar quarter that the various Rebate amounts are attributable to. The Contractor shall not enter into any agreement with a pharmaceutical manufacturer for Rebates with the impact to reduce or otherwise circumvent monies received from pharmaceutical manufacturers as being considered Rebates. Further, the Contractor will not require the State to enroll in programs, other than standard formulary participation without any exclusions (beyond those exclusions identified in the state's plan documents), to receive manufacturer payments.

c. The State shall have the ability at any time to exclude or block from coverage one or more drugs for any reason. If such changes result in a material impact to the Contractor's ability to meet the applicable rebate guarantee, Contractor shall notify the State within 30 calendar days of the State's requested change. Any changes the State then decides to pursue may result in a Contract amendment.

d. Contractor agrees to pay the State the greater of one hundred percent (100%) of total manufacturer revenue or the minimum Rebate per script guarantee. Specialty reconciliation will be on brand only. Generic specialty will be calculated as retail generic. Furthermore, the Contractor agrees to pay the State the minimum guarantee sixty (60) days after the end of a reporting quarter (calendar quarter). True-up to one hundred percent (100%) will occur with the first rebate check of the following year. In essence, this means that instead of the State receiving approximately only twenty-five percent (25%) of the total yield in a calendar year, the State would receive approximately seventy-five to eighty percent (75%-80%) in that calendar year.

A.17. Market Check Provision

a. The Contractor shall provide most favored nation ("MFN") terms wherein it shall not provide any similar account more favorable pricing terms than that provided to the State. If there are changes to any of the MFN measurement components or methodology and those changes are reasonably designed to achieve greater comparability under this provision, the State will approve In Writing before those changes are implemented. The Contractor must agree to a market check to compare the economics of the resultant contract. The Contractor shall provide two (2) financial terms market checks. The first market check will be performed at month four (4) – April 2020 - and the second market check will be at month thirty (30) – June 2022 - to comparable arrangements in the marketplace, including but not limited to aggregate value of the Discounts, minimum Rebates, Dispensing Fees, and Administration Fee pricing terms, for the purpose of recommending adjustments necessary to restore and maintain competitive advantage. The State's benefits consultant and actuarial consulting firm will determine similar employer groups for size and benefit structure to serve as comparison(s). If financial benchmark pricing indicates that the State's financial terms are no longer competitive, the Contractor shall offer to improve the State's pricing by, at least, the identified difference in value within forty-five (45) days of notification. The State's

contracted benefits and actuarial consulting firm shall complete the market checks at the State's request, and with the full cooperation of the PBM Contractor. There shall not be a minimum threshold of savings as a result of the market check in order for the Contractor to offer better pricing to the State. Any improved pricing as a result of the first market check shall be in place by January 2021 and any improved pricing as a result of the second market check shall be in place by January 2023.

A.18. Data Integration and Technical Requirements

a. The Contractor shall maintain an electronic data interface with the State's Edison System, for the purpose of processing Member enrollment information. The Contractor shall be responsible for providing and installing the hardware and software necessary. When the Contractor requires the exchange of PHI with the State. The State requires the use of second level authentication using the State's standard software product, which supports Public Key Infrastructure ("PKI"). The Contractor shall design a solution, in coordination with the State, to connect to the State's Secure File Transfer Protocol ("SFTP") server using a combination of the password and the authentication certificate. The initial sign-on and transmission testing will use a password. Certificate testing may also be performed during the test cycle. Subsequent production sign-on will be done using the authentication certificate. The Contractor will then download the file and decrypt the file in its secure environment. Additionally, federal standards require encryption of all electronic protected health data at rest as well as during transmission. The State uses public key encryption with Advanced Encryption Standard ("AES") to encrypt PHI. If the State adopts a different or additional encryption standard or tool in the future, the Contractor is expected, with adequate notice, to cooperate with the State to maintain the security of protected information according to all applicable state and federal standards.

b. Notwithstanding the requirement to maintain enrollment data, the Contractor shall not initiate data changes to the system without the State's approval. This prohibition shall include, but not necessarily be limited to: initiation, termination, and/or changes of coverage.

c. At least thirty (30) days prior to the go-live date specified in Contract Section A.30, the Contractor shall load, test, verify and make available online for use the State's eligibility information. The Contractor shall certify, In Writing, to the State that the Contractor shall utilize the eligibility files as provided by the State. The Contractor must not ask State to re-issue another file with the changes included; rather, Contractor must make manual changes to the file as needed and requested by the State.

d. Contractor must make changes to the eligibility file on a manual basis if requested by the State on an as-needed basis. Contractor must not ask State to re-issue another file with the changes included.

e. Contractor will receive eligibility files on a daily basis from the State.

f. Contractor must contact the State eligibility team anytime there are three hundred (300) or more terms or drop-offs before the daily eligibility file is loaded.

A.19 Data and Information Technology

a. The Contractor shall maintain, in its computer system, in-force enrollment records of all Members. Specifically, the Contractor shall perform the following tasks:

(1) Daily Enrollment Update: To ensure that Members' enrollment records remain accurate and complete, the Contractor shall retrieve, via secure medium (see A.18.a), daily enrollment data electronic transfer files from the State, in the State's Edison 834 file format, see RFP Appendix 7.11 for Members who are maintained in the State's Edison System (files will include full population records for all Members and will be in the format of ANSI ASC X12N, Version 005010X220, with some fields being customized by the State). Contractor understands and agrees that daily eligibility files will be provided to the Contractor by the State, and the Contractor shall make manual changes to the eligibility file (e.g. a request may come across from the State if a data element is preventing the file from loading in the Contractor's system.) Contractor shall make all manual changes requested by the State, and the State will not reissue another eligibility file. The Contractor shall contact the State eligibility team anytime there are three hundred (300) or more terms or drop-offs before the daily eligibility file is loaded.

(2) The Contractor and/or its subcontractors, as applicable, shall post ninety-eight percent (98%) of electronically transmitted enrollment updates within one (1) Business Day of receipt of the daily file and one hundred percent (100%) shall be posted within five (5) Business Days of receipt of the daily file.

(3) The Contractor and/or its subcontractors, as applicable, shall resolve all discrepancies identified by the processing of the enrollment file within one (1) Business Day of identification.

b. The Contractor shall add new groups to all systems within three (3) Business Days of receipt of necessary documents. The Contractor and/or its subcontractors, with collaboration from the State, shall resolve associated system errors, as identified through enrollment discrepancy resolution, in a timeframe required by the State. The Contractor shall document in an eligibility system modification log, the system error details, the proposed solution, and the final solution as required by the State. The Contractor shall update and submit this log quarterly (refer to Contract Attachment C, Reporting Requirements and Attachment B).

c. State Enrollment Data Match: Upon request by the State, not to exceed four (4) times annually, the Contractor shall submit to the State, in a secure manner, its full file of Members, by which the State may conduct a data match against the State's Edison database. The purpose of this data match will be to determine the accuracy with which the Contractor is maintaining its database of Members.

(1) The State will communicate results of this match to the Contractor, including any Contractor requirements, and associated timeframes, for resolving the discrepancies identified by the data match.

d. The Contractor shall reconcile, within ten (10) working days of receipt, payment information provided by the State (e.g. upon providing the State with a monthly invoice and the Contractor receives payment for this invoice, if the Contractor has questions or concerns about payment, Contractor must do so within ten (10) days). Upon identification of any discrepancies, the Contractor shall immediately notify the State.

(1) Contractor shall provide the State's DSS contractor with all of the State's claim data, data layouts, and data dictionaries in a timely manner and in the formats, layouts and specifications, including GPI and GCN for all prescription drug claims, specified by the DSS contractor in RFP Appendix 7.10.

(2) Contractor shall submit complete and accurate data to the State's DSS contractor by the fifteenth (15^{th}) day after the end of each month. Complete and accurate data is defined to be data that:

i. Contains records for all activity (e.g., pharmacy claims data, program participation) within the specified time periods;

ii. Has the same format and content as the agreed-upon record layout and data dictionary;

iii. Does not have unreported changes in either format or content; and

iv. Is submitted in a single record format.

(3) Contractor shall provide the data files at no charge to the State or the State's DSS contractor. Any charge by the DSS contractor to set up the Contractor shall be borne by the Contractor.

(4) If Contractor's Contract with the State is terminated, Contractor shall continue to provide run-out pharmacy claims data to the State's DSS contractor until the end of the agreed-upon run-out period.

(5) Contractor shall provide the data without any restrictions on its use.

(6) Contractor shall ensure that production data matches the test data in format, layout, and content.

(7) Contractor shall update valid values and maps in a timely manner and notify the State's DSS contractor of any such updates at least ten (10) Business Days before the scheduled data submission date.

e. The Contractor shall adhere to the additional requirements related to the State's DSS contractor listed in Contract Section C.3.

f. For each quarter, claims data shall meet the quality standards measured and reported by the State's DSS contractor on either a monthly or quarterly basis. The Contractor's data submission to the DSS contractor shall meet the following measures:

1. Date of birth: Data missing for ≤ 3% of claims;
2. Pharmacy provider ID missing: Data missing for ≤ 1.5% of claims; and
3. NDC or NDC 11 missing: Data missing for ≤ 1.5% of claims

g. The Contractor shall provide transmittal of pharmacy data via secure medium to any of BA's contractors including the TPAs, health management contractor(s), Behavioral Health/EAP contractor(s) or any other contractor or State fiduciary as identified by the State. Unless otherwise directed by the State, the Contractor shall provide, at no additional charge, daily data feeds of pharmacy claims to the third parties during the Term and following the Term until all claims incurred during the Term have been paid. This data shall be provided in the Middle Tier format which allows real time trading of deductibles, maximum out of pocket amounts and other such accumulator data. If so directed by the State, the Contractor shall pass a regular file to the State's TPAs showing an accumulator file of prescription drug payments by individual. Conversely, the Contractor shall be required to receive similar files from the State's TPAs for the same reason: to allow the State-sponsored plans to accurately maintain in real time Member and family deductibles and maximum out of pocket costs (pharmacy and medical combined). Contractor shall be expected to receive and send data and work with the State and its other Contractors on a regular basis to this end. At any time a deficiency or miscalculation exists either between the Contractor and one or more of the state's TPAs, the pharmacy Contractor must work with the TPAs to make the corrections necessary to the transmitted files in order to correct any and all deficiencies within ten (10) Business Days, unless otherwise approved by the State.

h. The Contractor shall load all current PAs, overrides, and open refills (Mail Order Service and retail) that exist for current Members from all existing PBMs no later than thirty (30) days prior to the go-live date.

i. At the State's request, the Contractor shall accept at least one (1) year of historical data from the State's previous PBM contractor. This includes, but is not limited to, pharmacy claims history, provider data, recipient data, preferred drug list, PAs, refills, lock-in and reference data. If requested, the data will be used to transfer prescriptions to the Contractor's Mail Order Service and Specialty Pharmacy.

j. The Contractor shall store claims data online for a minimum of twenty-four (24) months after the claim has been adjudicated.

k. The Contractor shall agree to transfer to the State, within sixty (60) days of notice of Contract termination, all required data and records necessary to administer the plan(s)/program(s), subject to state and federal confidentiality considerations. The transfer may be made electronically via secure medium, in a file format as specified by the State.

A.20. Provider Education

a. At the State's request, the Contractor shall develop and implement educational programs and notification processes for the Plan prescriber and pharmacy provider community. The Contractor shall design these programs and processes with the goal of improving awareness of Plan pharmacy program policies and procedures and increasing Formulary compliance rates. Educational initiatives shall include, but not be limited to: pharmacy provider and prescriber letters, Formulary distribution, POS messaging, training sessions, website postings of the Formulary and other educational materials. The Contractor shall implement agreed upon communication strategies through direct involvement with prescribers and pharmacy providers via a combination of site visits, telephone support, Internet-based application, and direct mail.

b. Educational topics may include: PA criteria and processes; how to access and use the Formulary; POS edits; Step Therapy criteria and processes; quantity level limits; and Specialty Medication processes.

c. The Contractor shall ensure that all prescribers and pharmacy providers have timely and complete information about all drugs on the Plan Formulary. The Contractor shall make such information available through written materials, Internet sites, and electronic personal data assistants ("PDA").

d. The Contractor shall develop and produce letters and other program materials to be shared with prescribers and pharmacy providers. Such materials shall contain information related to the operation of the Plan pharmacy program. The Contractor shall prepare and maintain a document suitable for printing or posting to the Contractor-managed splash page. The Contractor shall obtain prior approval In Writing from the State for all materials.

e. The Contractor shall distribute all PA call center toll-free telephone numbers, facsimile numbers, web addresses and e-mail addresses, as well as the appropriate mailing address for PA requests, at all prescriber and pharmacy provider training sessions and education programs.

f. If requested by the State, the Contractor shall offer recommendations to the State regarding provider education.

A.21. Appeals

a. The Contractor shall maintain a formal three (3) level grievance procedure, by which Members and providers may appeal decisions and disputes regarding pharmacy administration and pharmacy benefit coverage. This process must include at the third level an independent review organization ("IRO") as required by the PPACA. The Contractor shall comply with the appeals provisions set forth in the State's Plan Document. Certain pharmacy

issues are not appealable including, but not limited to, Copayment/Coinsurance amounts, Formulary decisions, and network coverage.

b. At least thirty (30) days prior to the go-live date, the Contractor shall provide to the State information describing in detail the Contractor's grievance procedures. The State reserves the right to review the procedure and make recommendations, where appropriate.

c. The Contractor shall decide Pre-Service Appeals within thirty (30) days and Post-Service Appeals within sixty (60) days. Ninety-five percent (95%) of Pre-Service Appeals shall be decided within thirty (30) days and ninety-five percent (95%) of Post-Service Appeals within sixty (60) days. The Contractor shall offer an expedited appeals process. If a denial of coverage or authorization can reasonably be expected to prevent a covered individual from obtaining urgently needed medications, then a request for an expedited consideration may be submitted by the Member, their duly authorized representative or treating physician. The Contractor shall determine if the request qualifies for an expedited review and shall respond with seventy-two (72) hours.

d. The Contractor shall include notification of a Member's right to appeal in any Member communications regarding pharmacy benefit coverage decisions.

e. The Contractor shall respond to all inquiries In Writing from the State within one (1) week after receipt of said inquiry. In cases where additional information to answer the State's inquiry is required, the Contractor shall notify the State immediately as to when the response can be furnished to the State.

f. The Contractor shall ensure that the State's pharmacy benefit program is fully compliant with all aspects of the PPACA and as additional regulations are implemented. The Administrative Fees in Contract Section C.3 are to include all possible work to ensure that the State and its PBM contractor are compliant with the PPACA.

A.22. Customer Services

a. The Contractor shall operate and maintain a dedicated toll-free customer service phone line manned by qualified benefits specialists for Members and pharmacy provider inquiries twenty-four (24) hours a day, seven days a week. Contractor personnel shall be trained to answer questions regarding all aspects of the State's pharmacy benefit including Plan design, participating pharmacies, clinical programs, clinical management programs, Mail Order Service pharmacy, and the Specialty network. The Contractor's toll-free customer service line shall be open and staffed with trained staff at least two (2) weeks prior to the go-live date.

b. All Member calls regarding pharmacy benefits including Copayments, deductibles, out of pocket maximums, network pharmacies, drug coverage, and coordination of benefits shall be directed to the Contractor's customer service center. The State's BA Service Center representatives only serve to answer questions about eligibility and that Contractor's

customer service center representatives should only refer eligibility-related issues back to Benefits Administration.

c. The Contractor's call center and all call center representatives/operators for whom our Members come in contact with will be physically located within the contiguous United States.

d. The call center shall have call management systems and communications infrastructure that can manage the potential call volume and achieve the performance.

e. The Contractor's call management systems shall be scalable and flexible so they can be adapted as needed, within negotiated timeframes where applicable, in response to program, benefit or enrollment changes.

f. The Contractor's call center shall be equipped to support and communicate with persons with a hearing or speech impairment via Telecommunications Relay Services (TRS) in compliance with the federal Americans with Disabilities Act.

g. The Contractor's call center shall have at least one Member services representative who is bilingual in English and Spanish and available twenty-four (24) hours a day, seven (7) days a week.

h. The toll free telephone number assigned to the State for Members to call for assistance with their pharmacy benefits questions will be exclusive to the State, will not be shared with any other client of the PBM, will not be changed during the Term without the approval of the State In Writing, and will be customized to include a greeting approved by the State.

i. The Contractor's call center shall maintain a first call resolution rate of ninety-two percent (92%) or greater.

j. The Contractor shall maintain an ASA of thirty (30) seconds and after answering the call the Contractor may only put callers on hold in order to (a) make outbound calls as necessary or (b) to research a caller's issue.

k. The Contractor's call center shall maintain a (1) telephone service factor ("TSF") of 80-20 meaning that eighty percent (80%) of calls are answered within twenty (20) seconds and (2) open call/inquiry closure rate of ninety-five percent (95%) within five (5) Business Days.

l. The Contractor shall close ninety-five percent (95%) of open call issues within five (5) Business Days.

m. The Contractor shall provide customer service/call center statistics for Members to the State on a quarterly basis.

n. The Contractor's call management systems shall provide greeting messaging when necessary. The Contractor may play canned music for the callers while they are on hold; the Contractor may also play messages about clinical programs that the State has adopted, and other subjects as approved by the State. The Contractor shall not play advertising or informational messages for callers while they are on hold unless approved in advance and In Writing by the State (or the State directs the Contractor to play certain messages). Additionally, the Contractor's systems shall provide a message that notifies callers that calls may be monitored by the Contractor and the State for quality control purposes.

o. The Contractor's call management system shall record and index all calls such that the Contractor can easily retrieve recordings of individual calls based on the phone number of the caller, the caller's name, the date/time of the call, or the call center representative who handled the call. The Contractor shall provide a full recording of each call upon the State's request, using only the Member's name or identifier to locate the call(s).

p. The Contractor shall have the ability to allow the State to monitor pre-recorded calls from a remote location.

q. The call management system shall transfer calls to other telephone lines as necessary and appropriate, including transfers to BA service center and other external call centers, as designated by the State. The Contract shall only refer or transfer calls to the BA's service center that are eligibility-related; benefits related questions or issues shall be handled by the Contractor's customer center staff.

r. The Contractor may use an automated interactive voice response ("IVR") system for managing inbound calls, provided that the caller always has the ability to leave the IVR system and wait in queue in order to speak directly with a live-voice representative rather than continue through additional prompts. The Contractor shall not have more than one (1) level of menu choices unless approved in advance and In Writing by the State. The Contractor's call decision tree and menu are subject to State review and approval.

s. The Contractor shall inform callers of their likely wait times as they enter the queue. Additionally, the Contractor shall have voice-mail capabilities such that callers can record messages when all Call center representatives/operators are occupied tending to other callers. The Contractor shall also provide a dial back option that allows callers to receive a call back from the next available call center representative.

t. The Contractor shall have the ability to make outbound calls without interrupting the ability of callers to continue to access the call center.

u. The call management system shall enable the logging of all calls, including:
   (1) The caller's identifying information (e.g., employee ID);
   (2) The call date and time;

(3) The reason for the call (using a coding scheme approved by the State in advance and In Writing);

(4) The call center representative/operator that handled the call;

(5) The length of call; and

(6) The resolution of the call (and if unresolved, the action taken and follow up steps required).

Additionally, the call management systems shall maintain a history of correspondence and call transactions for performance management, quality management and audit purposes. This history will contain the actual information, a date/time stamp that corresponds to when the transaction took place, the origin of the data management transaction (the State and/or the State's designee, the Customer, etc.) and the Contractor representative/operator that processed the transaction.

v. The Contractor shall provide Members and pharmacy providers with an option on the toll-free telephone number to immediately consult with a licensed pharmacist between the hours of 7am – 7pm Central Time Monday through Friday. Outside of the hours of 7am – 7pm Central Time Monday through Friday, Members and pharmacy providers will have an option to receive a call back from a pharmacist within one (1) hour. This help desk shall be available twenty-four (24) hours a day, seven days a week to respond to questions and problems from pharmacy providers and Members. The Contractor shall supply all the required information systems, telecommunications, and personnel to perform these operations.

w. The Contractor's customer service representatives shall have access to an application, which allows them to review alternative drug therapies (Formulary status, Generic Drug alternatives available, etc.) and run test claims for Members who may request this information.

x. The Contractor shall maintain a full service staff to respond to inquiries, correspondence, complaints, and problems. The Contractor shall answer, In Writing, ninety-five percent (95%) of written (mail and e-mail) inquiries from Members concerning requested information, including the status of claims submitted and benefits available through the pharmacy program within five (5) business and one hundred percent (100%) within ten (10) days.

A.23. Member Communication/Materials

a. The Contractor shall, as required by the State by the State, print and distribute all pharmacy benefit Member enrollment materials such as identification ("ID") cards, welcome packets, network directories, letters, administrative forms and manuals.

b. Unless otherwise specified, the Contractor shall be responsible for all costs related to the design, development, revision, printing, and distribution of all materials that are required to be produced. The Contractor shall ensure that up-to-date versions of all printed materials can be downloaded from the splash page. This provision excludes enrollment forms, which are the State's responsibility.

c. At the State's request, the Contractor shall notify Members, In Writing, of any pharmacy benefit plan changes (changes to Copayments/Coinsurance, Formulary changes, etc.) no less than thirty (30) days prior to the implementation of the change.

d. Postage and production costs incurred by the Contractor, which are the direct result of communications requested by the State for benefit plan changes that have been initiated by the State during mid-year (or otherwise outside the annual enrollment period), shall be treated as pass-through costs. Such costs shall be billed on a monthly basis to the State in addition to regular invoices and shall include substantiating documentation, including a line-item description of the postage and production costs incurred by the Contractor.

e. The Contractor shall ensure communications sent to Members are *specific* to the State's Plan design and not simply a rebranding/repackaging of standard book-of-business Member materials. Member handbooks or welcome kits/packets shall be customized for each of the various health plan options currently available to plan enrollees from one plan year to the next, including the specific Copayments or Coinsurance for the different drug tiers. Member Handbooks/welcome kits for the first plan year of the contract shall be mailed out to the entire all Members no later than twenty-one (21) days prior to go-live date.

   As new plan Members join the program, they should receive a Member handbook/welcome kit and ID card no later than ten (10) days from the date their initial enrollment was passed to the Contractor on the Edison 834 eligibility file. Further, Member handbooks/welcome kits shall only be issued to Members who transition from one health plan option to another during each fall's annual enrollment (a change in health plan necessitates a new welcome kit, as the drug Copayments or Coinsurance will change and Members will need to receive from the PBM a welcome kit for the new year and their new health plan showing their new pharmacy benefits). Such new customized Member handbooks/welcome kits must be mailed no later than December 15th of each calendar year to this subset of Members.

   Exemption of incidental pieces such as newsletters and health promotional pieces will be considered by the State if the Contractor guarantees that pieces will be generic in nature and do not address Plan eligibility issues or specific coverage issues. The welcome packet shall include, at a minimum, a welcome kit customized to the plan they are enrolled in along with the applicable drug Copayments or Coinsurance, an ID card, a URL to the customized splash page maintained by the Contractor, toll-free customer service number, Contractor's general website, general website logon information and a confidentiality statement. The State reserves the right to include text in various languages in order to assist those of limited English proficiency with where to call for further assistance as required by the Federal Register Nondiscrimination in Health Programs and Activities 81 FR 31375, 45 CFR 92.

f. The Contractor shall have the exclusive responsibility to write, edit, and arrange for clearance of materials (such as securing full time use of a stock photograph used in brochures for perpetuity) for any and all materials.

g. The Contractor shall distribute materials that are culturally sensitive and professional in content, appearance, and design with prior approval In Writing by the State.

h. The Contractor shall provide the State with draft versions of all communications materials and letters at least fourteen (14) days prior to planned printing, assembly and/or distribution (including web posting). The Contractor shall not distribute any materials until the State

issues approval In Writing to the Contractor for the respective materials. The State has and retains the ability to edit and customize all communication pieces mailed out by the Contractor to Members, including the right to require that the State branding "ParTNers for Health" logo be included on any Member letters or correspondence, if requested by the State.

i. The Contractor shall provide electronic templates of all finalized materials in a format that the State can easily alter, edit, revise, and update.

j. The Contractor shall, to the extent practicable, use relatively large and legible fonts in its materials. Additionally, the Contractor shall make maximum use of graphics to communicate key messages to populations with limited literacy or limited English proficiency. The Contractor shall also prominently display the call center's telephone number in large, bolded typeface and hours of operation on all materials.

k. Unless otherwise approved in advance by the State, the Contractor shall design all printed materials at the sixth (6th) grade reading level or lower using the Flesch-Kincaid Index or other suitable metric that the State approves in advance and In Writing. The Contractor shall evaluate materials using the entire text of the materials (except return addresses). When submitting draft materials to the State for approval, the Contractor shall provide a certification of the reading level of each piece of material.

l. The Contractor shall update web-based versions of all materials no less than quarterly. However, the Contractor shall produce corrected versions of the individual materials at the State's direction. Reimbursement for Member materials containing an error, which were approved by the State, shall occur as outlined in Section C.3 of the contract.

m. Member Identification Cards

(1) The Contractor shall provide eligible Members with ID cards and shall establish a process that allows enrollees to request replacement cards. The cost of creating and mailing ID cards shall be borne by the Contractor. The ID card shall bear in color the State's "ParTNers for Health" logo. The State has the final approval of ID card appearance and text, including the use or partial use of any Contractor's name, if applicable. The State reserves the right to request the Contractor to change the look, appearance, and text of the pharmacy ID cards at any time during the Term upon thirty (30) days' notice to the Contractor. The State reserves the right to require the removal or inclusion of any wording (unlimited in any way) on the pharmacy ID card for Members.

(2) Initial Member ID cards must be mailed to all Members no later than twenty-one (21) days prior to the go-live date as long as all implementation milestones have been met. ID cards shall be mailed to Members no later than ten (10) days from receipt of the new enrollment or change in enrollment. ID cards shall contain unique identifiers for each Member, which shall be the employee's unique Edison ID (the full eight (8) digit number with leading zeroes and no additional characters) provided on the monthly eligibility file. Such identifier shall NOT be the Member's federal Social Security Number. The number

used on the pharmacy ID card will be the number exactly as provided in the eligibility file. Ninety-five percent (95%) of welcome packets/ID cards shall be produced and mailed within ten (10) days of receipt of complete and accurate eligibility information.

(3) On an annual basis, at least two (2) months prior to the State's annual enrollment period, the Contractor shall provide to the State, in electronic format, information regarding the pharmacy benefit. Such information shall include a network list, toll-free customer service number, Contractor's general website, general website logon information, information on the retail, 90-day-At Retail, Mail Order Service, and specialty networks, current Formulary, clinical program policies and procedures (Step Therapy, PA, etc.), a confidentiality statement, procedures for accessing services, and other updates and/or changes that may be helpful to Members.

(4) Ninety-five percent (95%) of welcome packets containing I.D. cards will be produced and mailed no later than twenty-one (21) days prior to go-live date.

n. The Contractor shall use first class postage rate for all mailings, unless otherwise directed by the State.

o. Unless prior approved In Writing by the State, and in compliance with state and federal law, the Contractor shall not use information gained through this Contract, including utilization and pricing information, in marketing or expanding non-State business relationships or for any pecuniary gain.

A.24. Website

a. The Contractor shall have available an up-to-date Contractor website dedicated to the Plan pharmacy benefit. The website shall be available and fully operational, with the exception of Member data/PHI at least twenty-one (21) days prior to the go-live date. The Contractor shall design the website to aid prescribers, pharmacists and Members in all aspects of the pharmacy program. The Contractor shall update documents posted to the website within five (5) Business Days of the State's approval of changes to said documents.

b. The Contractor shall submit the text and screenshots of the website to the State for review and approval at least one (1) month prior to the go-live date. Additionally, the Contractor shall obtain prior approval In Writing from the State for any links from the site to a non-governmental website or webpage.

c. The Contractor shall have the responsibility to host the website on a non-governmental server, which shall be located within the United States. The Contractor shall have adequate server capacity and infrastructure to support the likely volume of traffic from Members without disruption or delay.

d. In addition to the Contractor's own website where this information may also be incorporated and found once a Member logs in, the Contractor shall maintain a pharmacy splash page that the Contractor maintains and regularly updates as new forms or lists become outdated and new ones are available. The splash page shall be available and fully operational no later than two (2) weeks prior to the State's annual enrollment period each year. This splash page shall contain PDFs of documents such as the State's preferred drug list ("PDL"), a list of medications requiring PA as well as directions on how to go about doing that; a list of medications with quantity limits and a listing of those medications and their respective limits; a list of Specialty Medications; a list of medications subject to Step Therapy requirements and what the step drugs are; a list of the 90-Day-At-Retail nationwide network pharmacies (in state alpha order, then by city alpha order), a list of the pharmacies in the Specialty Drug network, a letter explaining the State's coordination of benefits ("COB") process, detail for each of the various plan options offered by the State including what the Members' cost sharing would be for thirty (30) and ninety (90) day drugs, and other similar PDFs. Information must be available on a Contractor-maintained splash page without it being necessary for the Member to log in. In addition, a Member must have the ability to check individual claims history by logging into the Contractor's main website. Both locations (Contractor cobranded website and the splash page) would carry at the top of the page the State's "ParTNers for Health" logo in color.

e. The customized splash page shall be a cobranded website with the Contractor's logo and the State's "ParTNers for Health" logo both displayed in a prominent location. At a minimum, the website shall be updated quarterly to include:

(1) a current listing of the most recent Formulary or preferred drug list (with a prominent effective date shown on page 1 of the PDL);

(2) a list of all pharmacies in the national network whereby Members can fill a thirty (30) day prescription;

(3) a list of all pharmacies participating in the special 90-Day-At-Retail network;

(4) a list of all Specialty Pharmacies (especially those in Tennessee). These listings shall include pharmacy name, address, city, state, zip code, and phone number;

(5) a list of all pharmacies participating in the nationwide vaccine network for flu and pneumonia shots at $0 Copayment;

(6) a separate list of drugs that are considered Specialty Drugs that the Member may only obtain in thirty (30) day supply increments, and a list of drugs that require PA, and a list of drugs that have quantity limits or Step Therapy requirements.

f. In association with the State's annual enrollment period each fall, the Contractor shall update the splash page, no later than two (2) weeks prior to the first day of the annual enrollment period, with all information, documents, and pharmacy related benefits pertinent to each new Plan year.

g. To ensure accessibility among persons with a disability, the Contractor's website shall comply with Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d) and implementing regulations at 36 CFR 1194 Parts A-D.

h. Unless otherwise approved by the State, the Contractor's website shall contain a home page with general pharmacy information with links to dedicated areas for prescribers, pharmacists and Members. The Contractor shall utilize appropriate security measures, including password protection, to ensure the protection of Member data/PHI. Each area of the website shall contain information that shall answer the most common questions that each group would ask and documents required by each group to utilize the Plan pharmacy benefit. This shall include, but is not limited to a:

(1) Prescriber Page, which includes, but is not limited to:

i. An interactive Formulary, complete with hot-links from drugs to the PA criteria established for those drugs and also linked to drug specific PA forms and drug specific web-based PA application;

ii. A search function, which allows providers to enter a drug name and be routed to the drug in the interactive Formulary;

iii. Procedures for obtaining PAs, call center hours of operation and contact numbers;

iv. Printable education material specific to prescribers.

(2) Pharmacist Page, which includes, but is not limited to:

i. An interactive inquiry system using pharmacy providers' identifying number (NCPDP, NPI, etc.) to verify the status of pending payments, and other supported function(s) as deemed necessary by the State;

ii. An online listing of the Contractor's MAC drug list;

iii. Printable online pharmacy handbook and provider education material specific to pharmacists;

i. The website shall also have the following services/capabilities:

a. E-mail notification of next refill to Member, and

b. Cost comparison transparency tool, along with medication alternatives.

j. Contractor agrees to provide the Contractor's online services terms and conditions agreement during the implementation period. The Contractor shall not publish or distribute terms and conditions binding on plan members using Contractor's services under this Contract unless these terms and conditions are approved by the State In Writing. This includes terms and conditions on a website that plan members must click on to accept as a condition of using the Contractor's website for services or information relating to this Contract.

The agreed upon online services terms and conditions agreement must be approved and posted on the website at least twenty-one (21) days prior to the go-live date as stated in contract Section A.24.a.

A.25. Reporting & Systems Access

a. The Contractor shall, upon State request, submit monthly operational/performance reports by which the State can assess the Plan's activity and performance. The Contractor shall submit reports electronically, and shall include information such as enrollment, utilization, prescription sources and types, Plan expenses, Member demographic information and other

information as requested by the State. All standard reports shall be distributed to the State within forty-five (45) days of the end of the previous month. If the Contractor's ad-hoc reporting system that is made available to the State allowing the Director of Pharmacy Services to pull data in various forms and full ad-hoc capability, then the State may, in its sole authority, waive the requirement to provide this information.

b. The Contractor shall provide access to an online reporting system (e.g. eligibility system and claims history system) to BA staff no later than one (1) month prior to the system go-live date. Additional users must be added at any time at the State's request, with no limit to the number of users. The State will provide the Contractor with a list of the names, telephone numbers, and email addresses and specify to the Contractor what kind of access the State requires for each employee: read only, update eligibility, view historical claims history etc. and to which system (eligibility, claims history and detail, or both). The Contractor shall train BA staff with access to the Contractor's system on all Contractor systems and tools no later than one (1) month prior to the go-live date. This training must be conducted on-site at the BA office unless otherwise approved by the State. The State will provide laptop computers and Internet access, but the training materials, system, and trainer/teacher/coach must be provided by the Contractor and the teacher must be fully trained himself or herself on all the various system-generated reports, ad-hoc reports, and is able to fully explain and walk State staff through them in a clear, articulate manner.

c. To maintain the privacy of PHI, the Contractor shall provide to the State a method of securing e-mail for daily communications between the State and the Contractor. The Contractor shall set up TLS (Transport Layer Security) with the State.

d. At the State's request, the Contractor shall provide reporting specific to the activity and outcomes associated with all of the utilization management tools and programs provided by the Contractor. The Contractor shall deliver such reports to the State within five (5) Business Days of the State's request.

e. The Contractor shall provide the State access to an ad-hoc reporting liaison to assist in the development of our own ad-hoc reports that cannot be generated using the Contractor's standard reporting package. The Contractor shall deliver such reports to the State within five (5) Business Days of the State's request. If requested by the State, the Contractor shall deliver up to ten (10) reports annually deemed as "urgent" by the State within twenty-four (24) hours at no additional cost to the State.

f. The Contractor, as requested by the State, shall generate a file of Members on a monthly basis with a first fill during the previous month for any antidepressant or anti-anxiety medication. Contractor shall share via secure server or email this list of Members and Edison I.D. numbers with the State's EAP/BHO contractor so that said contractor may communicate with the identified Members on the State's behalf by notifying them of the EAP/BHO program and its associated benefits.

g. The Contractor shall provide the State a compliance report (also known as a quarterly report card), no later than sixty (60) days following the end of each quarter, which captures performance related to the requirements. See item #12 in Contract Attachment C.

h. The Contractor shall provide the State a report, no later than sixty (60) days following the end of each quarter, illustrating the Contractor's compliance with financial terms inclusive of AWP (or its equivalent), Discounted Ingredient Cost and Dispensing Fees. See item #10 in contract Attachment C.

i. The Contractor shall provide the State a report, no later than sixty (60) days following the end of each quarter, illustrating the Rebate payments due to the State summarized at the NDC or NDC-11. See item #9 in Contract Attachment C.

j. The Contractor, if requested by the State, shall assess on a quarterly and an annual basis the prevalence and incidence of potential opioid abuse within the insured State Group Plan population and provide a written narrative with facts and data/numbers to the State on a quarterly and annual basis. This report shall also include a detailed monitoring of providers to understand where the risk is the greatest. If, at any time, the State determines that this information is no longer useful, the State may direct the Contractor to cease assessment, measurement, and reporting.

k. The Contractor, if requested by the State, shall provide the State a monthly report describing open service issues at the plan level.

A.26. Member Satisfaction Survey

The Contractor shall perform, following review and approval by the State, an annual Member satisfaction survey specific to the State's Plan. The Contractor shall conduct the survey once annually during each calendar year at a time approved by the State and shall involve a statistically valid random sample of Members. The State reserves the right to review and mandate changes in the survey it feels are necessary to obtain valid, reliable, unbiased results. Those changes may include, but are not limited to, changes in the research design, units of analysis or observation, study dimension, sample size, sample frame, sample method, coding, or evaluation method. The survey question or questions should be specific to the services and touchpoints the Contractor has with our Members, rather than the benefits or benefits structure itself (i.e. Members should be rating the satisfaction they have with the Contractor and the services provided by the Contractor rather than their Copayments or Coinsurance which are not controlled by the Contractor.) Based upon the results of the survey, the Contractor and the State will jointly develop an action plan approved In Writing by the State, to correct problems or deficiencies identified through this activity. The level of overall customer satisfaction shall be equal to or greater than eighty-five percent (85%) in the first year of the Contract, and ninety percent (90%) in all subsequent year(s).

A.27. SLA Scorecard and Performance

a. The SLA scorecard measures the Contractor's performance against the desired outcomes listed in Contract Attachment D.

b. The Contractor shall be responsible for meeting or exceeding the KPIs throughout the Term. The Contractor and State shall review quarterly the Contractor's success in achieving its performance objectives for the prior quarter in which services were delivered. Such performance shall be

measured in accordance with KPIs and desired outcomes outlined in the SLA Scorecard (Contract Attachment D).

A.28. Audits Authority

a. Notwithstanding the records provision contained in Contract Section D.11, with provision by the State of thirty (30) days' notice, and with the execution of any applicable third party confidentiality agreements, the State or its qualified authorized representative (experienced in conducting pharmacy audits) has the right to examine and audit the services, pricing (including Rebates), and any provision of this Contract to ensure compliance with all program requirements and contractual obligations. For the purpose of audit requirements, Contractor shall include its parents, affiliates, subsidiaries and subcontractors. All eligibility and claims data belong to the State.

b. The State has sole authority to determine who to choose for any kind of audit: financial, pharmacy Rebates, or other. This includes state employees, state employees from the Comptroller's audit staff, and BA's consulting firm. This audit right extends to any subcontractors of the PBM (e.g. Rebate processor).

   If the State contracts with a private entity to conduct an audit of Contractor, the State will require the auditing entity to negotiate a reasonable non-disclosure agreement with the Contractor that will ensure that the auditor is independent, has no conflict of interest with the Contractor and has acceptable procedures in place to ensure that no information derived from the audit of Rebate or network pharmacy contracts is used in, or accessible to, any consulting function the auditor may provide. The PBM shall not attempt to limit the State's audit rights in any way or timeframe; the State in its sole authority and with execution of any confidentiality document shall be allowed to audit the PBM on any contracted service, Discount, Pass Through Transparent Pricing provision, claims processing, customer service, or any other provision of this contract by whomever the State in its sole authority deems it appropriate.

   In no instance shall the Contractor advise the State that one set of auditors is appropriate while another set is not. In addition, the State may audit or re-audit any time period at any time. Previous audits of a set of claims, pharmacies, time periods, or any other sort of audit does not negate the State's right to re-audit the same information again later. There shall be no audit blackout periods at any point during a year and any charges or fees in any form for any audits that the State chooses to exercise.

c. The State is responsible for the cost of the authorized third party representative for such audits.

d. The Contractor shall provide access, with thirty (30) days' notice from the State, at any time, and for three (3) years after final contract payment (longer if required by law), to the State or the State's authorized representative to examine and audit the services provided under this Contract.

e. Any claims extract that may be provided to the State Comptroller's audit staff for their audit purposes **must** include, among other standard fields, the adjudicated date (date the pharmacy was paid by the PBM) for each individual claim.

f. The Contractor shall comply with Tenn. Code Ann § 4-3-1021. This requires the BA to compile a report each July 1 using data from various audit reports completed during the year and publish the results in a report every July 1st to the Tennessee Speakers of the House and Senate, the Comptroller of the Treasury, and members of the Tennessee General Assembly. BA requires the participation and timely assistance of the Contractor to work with the actuaries and benefits analysts both in and outside the State to ensure that each report is completed timely. Compliance with this state law requires the BA to conduct various audits and similar activities of the Contractor throughout the year.

g. The State will have access to any data necessary to ensure the Contractor is complying which includes, but is not limited to, one hundred percent (100%) of claims data, which includes at least all NCPDP fields from the most current version and release; Retail Pharmacy contracts; pharmaceutical manufacturer; Mail Order Service and Specialty Pharmacy contracts to the extent they exist with other contractor(s); utilization management reviews; clinical program outcomes; appeals; information related to the reporting; etc.

h. Pharmacy Rebate audits can include, but are not limited to, review and examination of manufacturer Rebate contracts, Rebate payments, special Discounts, fee reductions, incentive programs or the like with pharmacy manufacturers, and program financial records as necessary to perform an accurate and complete audit of Rebates received by the State. Upon request by the State, or its designated authorized independent auditor, the Contractor shall provide full disclosure of Rebates received by the Contractor, its affiliates, subsidiaries, or subcontractors on behalf of the State. This disclosure shall include line item detail by NDC or NDC-11 and line item detail by pharmaceutical manufacturer showing actual cost remitted and other related claim and financial information as needed to satisfy the scope of the audit. One hundred percent (100%) of all drugs dispensed and paid for from the go-live date on January 1, 2020 until the termination of benefits shall be included in any kind of pharmacy audit, regardless of tier level (Generic Drug, preferred brand, or non-preferred brand or absence of a tier assignment), and without regard to enrollment plan type, number of Members enrolled in said Plan, Copayment/Coinsurance assigned by the State (or lack thereof), Spread or differential between drug tier Copayments/Coinsurance, or any kind of utilization.

i. The Contractor shall disclose to the State's authorized representative any Administrative Fees or other reimbursements received in connection with any Rebates, Discounts, fee reductions, incentive programs, or the like received by Contractor as a result of the drug manufacturer payments, which include volume of pharmaceutical use by, or on behalf of, the State. In addition, the Contractor shall, upon request by the State, disclose fees or other reimbursements received in connection with any grants, educational programs or other incentive programs received by the Contractor on behalf of the State.

j. The Contractor shall provide reasonable cooperation with requests for information, which includes but is not limited to the timing of the audit, deliverables, data/information requests and the Contractor's response time to the State's questions during and after the process. The Contractor shall also provide a response to all findings received within thirty (30) days, or at a later date based on the number and type of findings, as approved by the State.

k. The State is not responsible for time or any costs incurred by the Contractor in association with an audit including, but not limited to, the costs associated with providing reports, documentation, systems access, or space.

l. If the outcome of the audit results in an amount due to the State, one hundred percent (100%) of the payment of such settlement will be made by the Contractor within thirty (30) days of the Contractor's receipt of the final audit report. Any amount due the State which is not paid by the Contractor within thirty (30) days of the Contractor's receipt of the final audit report shall be subject to a compounding interest penalty of one percent (1%) per month. The Contractor may submit written comments on the audit report including explanations of or objections to the findings of the audit report. The State, in its sole discretion, may amend the audit findings or adhere to the original findings. The thirty (30) day payment period would be suspended and would not run between the time the State receives Contractor's comments and the time the State responds.

m. The Contractor must assist the State in identifying fraud and perform fraud investigations of Members and providers, in consultation with the State, for the purpose of recovery of overpayments due to fraud. Reviews shall include all possible actions necessary to locate and investigate cases of potential, suspected, or known fraud and abuse. In the event the Contractor discovers evidence that an unusual transaction has occurred that merits further investigation, the Contractor shall simultaneously inform the State and the Division of State Audit, in the Office of the Comptroller of the Treasury. The State will review the information and inform the Contractor whether it wishes the Contractor to:

(1) Discontinue further investigation if there is insufficient justification; or

(2) Continue the investigation and report back to the State and the Division of State Audit; or

(3) Continue the investigation with the assistance of the Division of State Audit; or

(4) Discontinue the investigation and turn the Contractor's findings over to the Division of State Audit for its investigation;

n. The Division of State Audit may request a full claims extract for their audit purposes at any time. Contractor shall work with State Audit to supply them a full claims extract including (but not limited to) such variables as date filled, pharmacy name, address, and phone number, drug name and NDC or NDC-11, quantity dispensed, gross cost, plan cost, Member cost, prescriber name and NPI, adjudicated (paid date; the date that the actual pharmacy was paid) – all for each claim processed under this contract and provided in any claims extract to the Division of State Audit.

o. The Contractor shall refer all media and legislative inquiries of any type to BA, which will have the sole and exclusive responsibility to respond to all such queries. However, the Contractor shall respond directly to audit requests from the Comptroller, to audit requests from divisions within the Department of Finance & Administration, and to subpoenas related

to this Contract; in all such instances, the Contractor shall copy the BA on all correspondence.

A.29. Pharmacy Audits

a. The Contractor shall audit at least five percent (5%) of network pharmacies in Tennessee annually. The same audits performed on the Contractor's Retail Pharmacy network will be conducted on the Mail Order Service and Specialty pharmacies.

b. The Contractor shall establish and maintain a process to detect and prevent errors, fraud or abusive pharmacy utilization by Members, pharmacies or prescribers. The Contractor shall contact pharmacies with aberrant claims or trends to gain an acceptable explanation for the finding or to submit a corrected claim. The Contractor shall develop a trend or log of aberrancies that shall be shared with the State – upon the State's request. Each quarter or upon the State's request, the Contractor shall summarize findings from the reports and share with the State to address program revisions.

c. The State may request that the Contractor initiate a field audit when desk audits consistently identify aberrations that cannot be explained by other means or upon requests from legal authorities or regulatory agencies. The objective of the field audit shall include financial recovery, and elimination of the aberrant practice. The Contractor shall have the qualified staff available to conduct field audits or have an agreement with a contractor acceptable to the State within ninety (90) days of the date the Contractor assumes full responsibility for the pharmacy benefits program go-live date.

A.30. Due Dates for Project Deliverables

Unless otherwise specified In Writing by the State, the Contractor shall adhere to the following schedule for the deliverables and milestones for which it is responsible under this Contract:

	Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates & Milestone Target Dates:
Plan Implementation			
1.	Pharmacy benefit go-live	A.4.a	January 1, 2020
2.	Kick-off meeting for all key Contractor staff	A.4.d	Within thirty (30) days after Contract effective date
3.	Implementation plan and timetable	A.4.e	Thirty (30) days after Effective Date
4.	On-site implementation meeting	A.4.f	April 15, 2019 (On or before)
5.	State readiness review	A.4.g	November 1, 2019 (On or before)
6.	Call center onsite visit	A.4.i	November 1-30, 2019 and again after go live date, January 1-30, 2020
7.	Implementation Performance Assessment	A.4.k	February 15, 2020 (On or before)

	Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates & Milestone Target Dates:
8.	Initial Formulary Submission	A.4(e)(8) and A.9(a)	Sixty (60) days before go-live date
Staffing			
9.	Account Team satisfaction survey	A.5.g	Annually in January
POS Claims Adjudication			
10.	Business continuity/Disaster Recovery results	E.9.b	December 1, 2019, and annually thereafter.
Pharmacy Network			
11.	Network lists available on website	A.8.c	December 1, 2019
12.	Updated network lists	A.8.c	Quarterly after go-live date
13.	Mail Order Service website operational	A.8.g.(10)	December 1, 2019
14.	Network Access report	A.8.k	Annually in January
15.	Quarterly network changes report	A.8.l	Within five (5) working days of the end of each quarter following go-live date
Formulary Management			
16.	Formulary compliance report	A.9.d	Quarterly after go-live date
Clinical Programs			
17.	Therapeutic substitution and Generic Drug dispensing program reporting	A.12.d	Annually in January
18.	Disclosure of PA criteria and procedures	A.12.h.(1)	December 1, 2020 (On or before)
19.	PA Reporting	A.12.h.(5)	Quarterly after go-live date
Retro-DUR			
20.	Profile review focus and methodology	A.14.b	Thirty (30) days prior to initial review start date
21.	DUR and Retro-DUR presentations	A.14.e.(1)	Up to four (4) times annually, as requested by the State
22.	Retro-DUR Outcomes	A.14.e.(2)	Quarterly after go-live date
Financials			
23.	Annual Ingredient Cost reconciliation	A.15.b.10	Annually during the first quarter of each calendar year for the previous calendar year
24.	Dispensing Fee annual reconciliation	A.15.c.(1)	Annually during the first quarter of each calendar year for the previous calendar year
25.	Rate Guarantees	C.3.n	Within forty-five (45) days following each quarter

	Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates & Milestone Target Dates:
Pharmacy Rebates			
26.	Rebate and Administrative Fee reporting	C.3.r	Quarterly after go-live date
27.	Rebate annual reconciliation	C.3.r	First quarter each calendar year
Data Integration & Technical Requirements			
28.	Eligibility file acceptance	A.18.c	December 1, 2019
29.	Daily enrollment update	A.19.a.(1)	Daily after go-live date
30.	Daily File Transmission Statistics	A.19.a.(2)	Within twenty-four (24) hours of receipt of weekly file
31.	State enrollment data match	A.19.c	Up to four (4) times annually, as requested by the State
32.	Duplicate data processing records	E.9.b.	On or before the Contract termination or cancellation
33.	Claims data transmission to DSS contractor	A.19.d.(2)	Fifteen (15) days following the end of each calendar month
34.	Claims data transmission to third parties	A.19.g	Daily, unless otherwise directed by the State
35.	Load PAs, overrides, and open refills	A.19.h	December 1, 2019
36.	Claims data transmission to State	A.19.k	Within sixty (60) days of notice of Contract termination
Provider Education			
37.	Provider education recommendations	A.20.f	Annually in January
Appeals			
38.	Contractor grievance procedures	A.21.b	December 1, 2019
Customer Services			
39.	Customer service/call center statistics	A.22.m	Quarterly after go-live date
Member Communication/Materials			
40.	I.D. cards	A.23.m.(2)	December 10, 2019
41.	Open Enrollment information	A.23.m.(3)	Annually in August
42.	Initial welcome packets	A.23.m.(4)	December 10, 2019
43.	Ongoing welcome packets	A.23.e	Within ten (10) days of receipt of enrollment
Website			
44.	Website go-live	A.24.a	December 10, 2019
45.	State review of website	A.24.b	December 1, 2019

	Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates & Milestone Target Dates:
46.	Splash page	A.24.d; A.24.f.	Two (2) weeks prior to the annual enrollment period
Reporting and Systems Access			
47.	Operational/Performance reports	A.25.a	Monthly, within fifteen (15) days of the end of the previous month
48.	Reporting system access	A.25.b	December 1, 2019
49.	Eligibility system access	A.25.b	December 1, 2019
50.	State staff systems training	A.25.b	December 1, 2019
51.	Compliance report	A.25.g	Sixty (60) days following the end of each quarter after go-live
52.	Financial terms compliance report	A.25.h	Sixty (60) days following the end of each quarter after go-live
53.	Rebate payments report	A.25.i	Sixty (60) days following the end of each quarter after go-live
54.	Open service issues	A.25.k	Monthly after go-live
55.	FedRamp, ISO 27000 or SOC2 Type II report	E.9	Within thirty (30) days of the contract effective date and annually thereafter (in addition to periodic requests for bridge reports from State Audit)
Member Satisfaction Survey			
56.	Member satisfaction survey	A.26	Annually
Pharmacy Audits			
57.	Network pharmacy audits	A.29.a	Annually
58.	Aberrancy findings	A.29.b-c	As requested by the State
59.	Field audit staff	A.29.c	January 31, 2020

A.31. Warranty. Contractor represents and warrants that the term of the warranty ("Warranty Period") shall be the greater of the Term of this Contract or any other warranty generally offered by Contractor, its suppliers, or manufacturers to customers of its goods or services. The goods or services provided under this Contract shall conform to the terms and conditions of this Contract throughout the Warranty Period. Any nonconformance of the goods or services to the terms and conditions of this Contract shall constitute a "Defect" and shall be considered "Defective." If Contractor receives notice of a Defect during the Warranty Period, then Contractor shall correct the Defect, at no additional charge.

Contractor represents and warrants that the State is authorized to possess and use all equipment, materials, software, and deliverables provided under this Contract.

Contractor represents and warrants that all goods or services provided under this Contract shall be provided in a timely and professional manner, by qualified and skilled individuals, and in conformity with standards generally accepted in Contractor's industry.

If Contractor fails to provide the goods or services as warranted, then Contractor will re-provide the goods or services at no additional charge. If Contractor is unable or unwilling to re-provide the goods or services as warranted, then the State shall be entitled to recover the fees paid to Contractor for the Defective goods or services. Any exercise of the State's rights under this Section shall not prejudice the State's rights to seek any other remedies available under this Contract or applicable law.

A.32. Inspection and Acceptance. The State shall have the right to inspect all goods or services provided by Contractor under this Contract. If, upon inspection, the State determines that the goods or services are Defective, the State shall notify Contractor, and Contractor shall re-deliver the goods or provide the services at no additional cost to the State. If after a period of thirty (30) days following delivery of goods or performance of services the State does not provide a notice of any Defects, the goods or services shall be deemed to have been accepted by the State.

B. CONTRACT TERM:

This Contract shall be effective on June 1, 2019 ("Effective Date") and extend for a period of seventy-three (73) months after the Effective Date ("Term"). The State shall have no obligation for goods or services provided by the Contractor prior to the Effective Date.

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed WRITTEN DOLLAR AMOUNT ($NUMBER). This Contract does not grant the Contractor any exclusive rights. The State does not guarantee that it will buy any minimum quantity of goods or services under this Contract. Subject to the terms and conditions of this Contract, the Contractor will only be paid for goods or services provided under this Contract after a purchase order is issued to Contractor by the State or as otherwise specified by this Contract.

C.2. Compensation Firm. The payment methodology in Contract Section C.3. of this Contract shall constitute the entire compensation due the Contractor for all goods or services provided under this Contract regardless of the difficulty, materials or equipment required. The payment methodology includes all applicable taxes, fees, overhead, and all other direct and indirect costs incurred or to be incurred by the Contractor.

C.3. Payment Methodology. The Contractor shall be compensated, beginning no earlier than January 1, 2020, based on the payment methodology for goods or services authorized by the State in a total amount as set forth in Contract Section C.1.

a. The Contractor's compensation shall be contingent upon the satisfactory provision of goods or services as set forth in Contract Section A.

b. The Contractor shall be compensated based upon the following payment methodology:

Service Description	**Amount** (per compensable increment)				
	1/1/20[(1)] – 12/31/20	**1/1/21 – 12/31/21**	**1/1/22 – 12/31/22**	**1/1/23 – 12/31/23**	**1/1/24 – 12/31/24**
FEES (Guaranteed Maximum PMPM)					
Administration Fee Per Member Per Month	$ Amount Per Member Per Month	$ Amount Per Member Per Month	$ Amount Per Member Per Month	$ Amount Per Member Per Month	$ Amount Per Member Per Month
Clinical Fee Per Member Per Month	$ Amount Per Member Per Month	$ Amount Per Member Per Month	$ Amount Per Member Per Month	$ Amount Per Member Per Month	$ Amount Per Member Per Month
DISPENSING FEES (Guaranteed Maximum Average Per Claim)					
Retail – Brand	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim
Retail – Generic	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim
90-Day Retail – Brand	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim
90-Day Retail – Generic	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim
Mail Order Service – Brand	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim
Mail Order Service – Generic	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim
All Brand Specialty Pharmacy Claims [(2)]	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim
RETAIL NETWORK DISCOUNTS (Guaranteed Minimum Average)					
Brand	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage

Service Description	Amount (per compensable increment)				
	1/1/20[(1)] – 12/31/20	**1/1/21 – 12/31/21**	**1/1/22 – 12/31/22**	**1/1/23 – 12/31/23**	**1/1/24 – 12/31/24**
Generic	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage
90-DAY RETAIL NETWORK DISCOUNTS (Guaranteed Minimum Average)					
Brand	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage
Generic	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage
MAIL ORDER SERVICE NETWORK DISCOUNTS (Guaranteed Minimum Average)					
Brand	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage
Generic	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage
SPECIALTY NETWORK DISCOUNTS (Guaranteed Minimum Average)					
All Brand Specialty Pharmacy Claims [(2)]	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage	AWP minus Percentage
REBATES PER CLAIM (Guaranteed Minimum Per Script)					
All Retail Claim Basis (Brand & Generic)	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim
All 90-Day Retail Claim Basis (Brand & Generic)	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim
All Mail Order Service Claim Basis (Brand & Generic)	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim
All Brand Specialty Pharmacy Claims [(2)]	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim	$ Amount Per Claim

[(1)] Based on the go-live date listed in Contract Section A.29. If this go-live date is not met, the payment for

Service Description	Amount (per compensable increment)				
	1/1/20[(1)] – 12/31/20	**1/1/21 – 12/31/21**	**1/1/22 – 12/31/22**	**1/1/23 – 12/31/23**	**1/1/24 – 12/31/24**
services listed above will be delayed accordingly based on the modified go-live date. [(2)] Any Generic Specialty Pharmacy claims will fall into the retail generic category. Rebates must be guaranteed on an all-claims basis; not rebateable basis. PMPM fees must be guaranteed regardless of fluctuations in enrollment. For purposes of pricing, a claim shall be defined as any single processed paid prescription.					

c. The State reserves the right to review files prior to issuing payment and to hold or adjust any payment that is not satisfactory to the State. If the Contractor submits a claims payment request and the State overpays the claim, then the State may withhold the overpaid monies.

d. After Contract Effective Date, the Contractor shall use the post-settlement AWP for this Contract's pricing terms.

e. The State authorizes the Contractor to retain monies received through subrogation, on a per patient basis, of no more than five percent (5%) of the gross recoveries received. The Contractor may retain an additional twenty percent (20%) of the gross recoveries, when such recoveries are made by subrogation subcontractor(s). The Contractor's subrogation processes shall include the recovery of claims paid as a result of work related illnesses or injuries relative to worker's compensation claims

f. The State will fund the Contractor for the total issue amount of the payments, net of cancellations, voids or other payment credit adjustments, at least weekly provided the Contractor's payment process includes timely settlement of ACH transactions. Unless otherwise provided In Writing and approved by the State, the Contractor shall notify the State of the week's funding requirement amount. The State requires the Contractor to ACH debit the appropriate funds from a designated State bank account. The Contractor acknowledges and agrees that since the State intends to fund payments at the time of issuance, the State will not maintain a separate bank account or an escrow account with the Contractor or to otherwise pre-fund an account.

h. The State will fund the Contractor monthly for the administration fee based on the State's record of eligible Members as of the first day of the month.

i. The Contractor shall guarantee that the Dispensing Fee per claim is based on Paid Claims only not claims that are reversed or rejected.

j. The Contractor shall guarantee that U&C priced claims will not be assessed a Dispensing Fee.

k. The Contractor shall guarantee that the average Dispensing Fee per claim, if any, shall not exceed the guaranteed maximum average. Retail claims priced using the U&C price (or submitted price, etc.) will be NOT be included in the guaranteed maximum Dispensing Fee per claim.

l. The Contractor shall guarantee that all Discounts and services and Administrative Fees are guaranteed for the life of this contract, including any optional contract extensions executed by the State.

m. The Contractor shall guarantee that the terms presented are for the entire Contract period, including any optional contract extensions, and do not require the State to implement any plan designs or programs that are different from the plan design and programs currently in place.

n. The Contractor shall guarantee that the terms presented are State-specific, not book-of-business averages or Discount guarantees.

o. The contractor shall guarantee that the guaranteed Discount off AWP shall not exclude any products from the calculations (e.g., U&C claims, those Generic Drugs during their exclusivity period, "Specialty" Drugs processed at retail), with the exception of Compound Prescriptions and powders, which shall be excluded.

The contractor shall guarantee that the calculation of each pricing guarantee (AWP Discount, Rebates, Dispensing Fees) shall not include zero balance claims where the Member pays one hundred percent (100%) of the cost of the drug, regardless of Plan type Member is enrolled in (PPO, CDHP). The Contractor will calculate the achieved Discounts with the following formula: [1 minus (total Discounted AWP Ingredient Cost – excluding Dispensing Fees and penalties due to DAW claims and prior to application of Copayments – of applicable prescription drug claims for the measurement period divided by total un-Discounted AWP Ingredient Cost (both amounts will be calculated as of the date of adjudication) for the measurement guarantee period)]. Discounted Ingredient Cost will always be the lowest of the AWP Discount, MAC or U&C adjudication methodology.

p. The Contractor shall individually measure the guaranteed minimum average Discounts and fees for the retail networks, Mail Order Service pharmacy program, specialty network and 90-day-at Retail Pharmacy network. Over performance in one network area shall not offset under performance in other network areas. The Contractor shall individually measure specific brand Discounts, Generic Drug Discounts and Dispensing Fee components of each contract guarantee. Over performance in one contract area will not offset under performance in other contract areas. The Contractor shall measure guaranteed Discounts and Dispensing Fees annually within ninety (90) days following each quarter and reconcile with the State annually during the first quarter of the following calendar year. The Contractor shall reimburse the State the difference between actual average Discounts and fees and the guaranteed minimum average Discounts and fees by cash or check only. Credits to the Plan are not acceptable unless otherwise approved by the State In Writing. The Contractor will pay one hundred percent (100%) of any Discount guarantee shortfall to the State within forty-five (45) days of the close of each annual reconciliation period with the State retaining one hundred percent (100%) of any savings above the guarantees. Further, should the Contractor miss

the annual retail Generic Drug Discount guarantee by at least two (2) percentage points, the State will receive one hundred percent (100%) of the shortfall plus an additional payment of ten (10) percent of the shortfall amount (under-performance payment). The Contractor will not be able to offset or recoup any under-performance payment in any reconciliation. The Contractor shall measure each quarter the Rebate guarantee within one hundred twenty (120) days of the close of the measurement period with one hundred percent (100%) true-up at calendar year end. Specialty reconciliation will be on Brand only. Generic specialty will be calculated as retail Generic.

q. The Contractor shall pay to the State one hundred percent (100%) of the Total Manufacturer Value collected based, directly or indirectly, on the State's claims. The Contractor shall provide the State with the greater of (i) one hundred percent (100%) of the Total Manufacturer Value, or (ii) the guaranteed Rebates.

r. The Contractor shall pay out to the State all Total Manufacturer Value earned by the State regardless of termination of this contract.

s. The Contractor shall remit to the State no less frequently than quarterly a check for all Total Manufacturer Value obtained on behalf of the State due to the use of pharmaceuticals by Members for the Rebates accrued during the claim period ending six (6) months prior to the Rebate payment date. Rebate and Administrative Fee reporting shall also be submitted quarterly based on the State's NDC or NDC-11 utilization to demonstrate the level of Rebate Pass-Through Transparent Pricing. The Contractor shall pay, on a quarterly basis the greater of the minimum Rebate guarantees or the actual collected Rebates for the previous calendar quarter. Such payment shall occur no later than one hundred twenty (120) days after the end of a calendar quarter with a true up to one hundred percent (100%) to occur no later than one hundred twenty (120) days after the end of the calendar year for the previous calendar year. For purposes of rebate reconciliation, specialty drug reconciliation will be on Brand only. Generic specialty drugs will be calculated as retail Generic.

t. The Contractor shall reconcile all rebates for the previous calendar quarter within one hundred twenty (120) days after the end of that quarter and remit payment to the State. True-up for the whole calendar year shall occur within one hundred twenty (120) days after the end of the calendar year and payment for any amount still owed to the State must be made by the Contractor by the one hundred twentieth (120th) day after the end of the calendar quarter.

u. The State shall reimburse the Contractor for the following, selected actual costs in the performance of this Contract:

(1) Postage. The State shall reimburse the Contractor for the actual cost of postage for mailing materials produced at the specific request of the State. Postage for materials and mailings referenced in the contract (ID cards, welcome packets, welcome fliers etc.) are the sole responsibility of the Contractor.

(2) Printing / Production (refer to Contract Section A.23.d.). Subject to compliance with Section E.8., the State shall reimburse the Contractor an amount equal to the actual cost

of document printing/production as required and authorized by the State.

Notwithstanding the foregoing, the State retains the option to authorize the Contractor to deliver a product to be printed, approve and accept the product but not use the Contractor to print the material. In those situations, the State shall have the discretion to use other printing and production services at its disposal.

v. The Contractor shall reimburse, when necessary and appropriate, monies to plan Members when an overpayment has occurred by the Member.

w. The contractor shall maintain the thirty (30) day and ninety (90) day supply limits for Members as appropriate; however, in certain circumstances where Members are vacationing or traveling for longer periods of time the State – at its sole discretion – may grant a courtesy override depending on the individual circumstances. The Contractor in any such instance shall contact the State to inquire if an extended supply or courtesy vacation override may be approved. In these instances, the Contractor shall make special provision for the Member to pay the applicable cost sharing for the extended vacation override (e.g. multiple Copayments or Coinsurance). Further, the Contractor shall keep detailed records related to such in its POS and financial systems in case of audit.

x. The pricing guarantees are NOT contingent upon the State maintaining a minimum number of active or retiree Members.

y. The Contractor agrees that amounts owed to the State including Rebates, guarantee shortfalls, recoveries identified during claims audits, will be paid by the appropriate due date. Any amounts unpaid after the stated due date will bear interest at nine percent (9%) per year accruing after the due date until payment is received for all payments due to the State.

z. The Contractor will agree to pay Discount and Dispensing Fee shortfalls as well as minimum guaranteed manufacturer payments after the Effective Date.

aa. The Contractor will NOT require the State to make any Plan design changes or implement any new programs in order to receive or maintain Discount, Dispensing Fee or Rebate guarantees.

bb. The Contractor's overall effective Discount guarantees for Brand Specialty Drugs will include: new drugs added to the list of Specialty Drugs each year and Limited Distribution Specialty Drugs that the Contractor's Specialty Pharmacy has access to. For purposes of annual financial reconciliation, Specialty drug reconciliation will be on brand only. Generic specialty will be calculated as retail generic.

cc. Any Rebates received from manufacturers after the reconciliation will be applied to the next reconciliation and will be clearly noted in the next reconciliation.

dd. If the State chooses to implement POS rebates for any or all plan options, the Contractor will administer Rebates at the POS at the NDC-11 level.

ee. Payments from the State to the Contractor are allowed, if the State implements any Contractor value-based payment arrangements, as referenced in Contract Section A.10.b

C.4. At-Risk Performance Payments and SLA Scorecard:

a. The Parties shall conduct a scorecard assessment (Contract Attachment D), beginning after the go-live date, on a quarterly basis (every three months) during the Term.

b. Based on the SLA Scorecard, Contractor shall send the State an At-Risk Performance Payment (if applicable) quarterly (every three months) during the Term in accordance with Contract Attachment D. This payment is due within forty-five (45) days of the quarterly SLA scorecard assessment.

C.5 Travel Compensation. The Contractor shall not be compensated or reimbursed for travel time, travel expenses, meals, or lodging.

C.6. Invoice Requirements. The Contractor shall invoice the State only for goods delivered and accepted by the State or services satisfactorily provided at the amounts stipulated in Contract Section C.3., above. Contractor shall submit invoices and necessary supporting documentation, no more frequently than once a month, and no later than thirty (30) days after goods or services have been provided to the following address:

Seannalyn Brandmeir, Procurement & Contracting Manager
Tennessee Department of Finance & Administration
Benefits Administration Division
William R. Snodgrass Tennessee Tower
312 Rosa L Parks Avenue, Suite 1900
Nashville, Tennessee 37243

a. Each invoice, on Contractor's letterhead, shall clearly and accurately detail all of the following information (calculations must be extended and totaled correctly):

(1) The Contractor shall submit invoices for Clinical Fees no more often than monthly, with all necessary supporting documentation including the invoice number (assigned by the Contractor);

(2) Invoice date;

(3) Contract number (assigned by the State);

(4) Customer account name: Department of Finance and Administration, Division of Benefits Administration

(5) Customer account number (assigned by the Contractor to the above-referenced Customer);

(6) Contractor name;

(7) Contractor Tennessee Edison registration ID number;

(8) Contractor contact for invoice questions (name, phone, or email);

(9) Contractor remittance address;

(10) Description of delivered goods or services provided and invoiced, including identifying information as applicable;

(11) Number of delivered or completed units, increments, hours, or days as applicable, of each good or service invoiced;

(12) Applicable payment methodology (as stipulated in Contract Section C.3.) of each good or service invoiced;

(13) Amount due for each compensable unit of good or service; and

(14) Total amount due for the invoice period.

b. The timeframe for payment (or any Discounts) begins only when the State is in receipt of an invoice that meets the minimum requirements of this Contract Section C.5. Contractor's invoices shall:

(1) Only include charges for goods delivered or services provided as described in Contract Section A and in accordance with payment terms and conditions set forth in Contract Section C;

(2) Only be submitted for goods delivered or services completed and shall not include any charge for future goods to be delivered or services to be performed;

(3) Not include Contractor's taxes, which includes without limitation Contractor's sales and use tax, excise taxes, franchise taxes, real or personal property taxes, or income taxes; and

(4) Include shipping or delivery charges only as authorized in this Contract.

c. The timeframe for payment (or any discounts) begins only when the State is in receipt of an invoice that meets the minimum requirements of this Contract Section.

C.7. Payment of Invoice. A payment by the State shall not prejudice the State's right to object to or question any payment, invoice, or other matter. A payment by the State shall not be construed as acceptance of goods delivered, any part of the services provided, or as approval of any amount invoiced.

C.8. Invoice Reductions. The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment that is determined by the State, on the basis of audits conducted in accordance with the terms of this Contract, to not constitute proper compensation for goods delivered or services provided.

C.9. Deductions. The State reserves the right to deduct from amounts, which are or shall become due and payable to the Contractor under this or any contract between the Contractor and the State of Tennessee, any amounts that are or shall become due and payable to the State of Tennessee by the Contractor.

C.10. Prerequisite Documentation. The Contractor shall not invoice the State under this Contract until the State has received the following, properly completed documentation.

a. The Contractor shall complete, sign, and present to the State the "Authorization Agreement for Automatic Deposit Form" provided by the State. By doing so, the Contractor acknowledges and agrees that, once this form is received by the State, payments to the Contractor, under this or any other contract the Contractor has with the State of Tennessee, may be made by ACH; and

b. The Contractor shall complete, sign, and return to the State the State-provided W-9 form. The taxpayer identification number on the W-9 form must be the same as the Contractor's Federal Employer Identification Number or Social Security Number referenced in the Contractor's Edison registration information.

D. MANDATORY TERMS AND CONDITIONS:

D.1. Required Approvals. The State is not bound by this Contract until it is duly approved by the Parties and all appropriate State officials in accordance with applicable Tennessee laws and regulations. Depending upon the specifics of this Contract, this may include approvals by the Commissioner of Finance and Administration, the Commissioner of Human Resources, the Comptroller of the Treasury, and the Chief Procurement Officer. Approvals shall be evidenced by a signature or electronic approval.

D.2. Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this Contract shall be in writing and shall be made by certified, first class mail, return receipt requested and postage prepaid, by overnight courier service with an asset tracking system, or by email or facsimile transmission with recipient confirmation. All communications, regardless of method of transmission, shall be addressed to the respective Party at the appropriate mailing address, facsimile number, or email address as stated below or any other address provided in writing by a Party.

The State:

Seannalyn Brandmeir
Tennessee Department of Finance & Administration
Division of Benefits Administration
312 Rosa L. Parks Avenue, Suite 1900
Nashville, TN 37243
Seannalyn.Brandmeir@tn.gov
Phone: 615-532-4598
Fax: 615-253-8553

The Contractor:

Contractor Contact Name & Title
Contractor Name
Address
Email Address
Telephone # Number
FAX # Number

All instructions, notices, consents, demands, or other communications shall be considered effective upon receipt or recipient confirmation as may be required.

D.3. Modification and Amendment. This Contract may be modified only by a written amendment signed by all Parties and approved by all applicable State officials.

D.4. Subject to Funds Availability. The Contract is subject to the appropriation and availability of State or federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the State reserves the right to terminate this Contract upon written notice to the Contractor. The State's exercise of its right to terminate this Contract shall not constitute a breach of Contract by the State. Upon receipt of the written notice, the Contractor shall cease all work associated with the Contract. If the State terminates this Contract due to lack of funds availability, the Contractor shall be entitled to compensation for all conforming goods requested and accepted by the State and for all satisfactory and authorized services completed as of the termination date. Should the State exercise its right to terminate this Contract due to unavailability of funds, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages of any description or amount.

D.5. Termination for Convenience. The State may terminate this Contract for convenience without cause and for any reason. The State shall give the Contractor at least thirty (30) days written notice before the termination date. The Contractor shall be entitled to compensation for all conforming goods delivered and accepted by the State or for satisfactory, authorized services completed as of the termination date. In no event shall the State be liable to the Contractor for compensation for any goods neither requested nor accepted by the State or for any services neither requested by the State nor satisfactorily performed by the Contractor. In no event shall the State's exercise of its right to terminate this Contract for convenience relieve the Contractor of any liability to the State for any damages or claims arising under this Contract.

D.6. Termination for Cause. If the Contractor fails to properly perform its obligations under this Contract, or if the Contractor materially violates any terms of this Contract ("Breach Condition"), the State shall provide written notice to Contractor specifying the Breach Condition. If within thirty (30) days of notice, the Contractor has not cured the Breach Condition, the State may terminate the Contract and withhold payments in excess of compensation for completed services or provided goods. Notwithstanding the above, the Contractor shall not be relieved of liability to the State for damages sustained by virtue of any breach of this Contract by the Contractor and the State may seek other remedies allowed at law or in equity for breach of this Contract.

D.7. Assignment and Subcontracting. The Contractor shall not assign this Contract or enter into a subcontract for any of the goods or services provided under this Contract without the prior written approval of the State. Notwithstanding any use of the approved subcontractors, the Contractor shall be the prime contractor and responsible for compliance with all terms and conditions of this Contract. The State reserves the right to request additional information or impose additional terms and conditions before approving an assignment of this Contract in whole or in part or the use of subcontractors in fulfilling the Contractor's obligations under this Contract.

D.8. Conflicts of Interest. The Contractor warrants that no part of the Contractor's compensation shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Contractor in connection with any work contemplated or performed under this Contract.

The Contractor acknowledges, understands, and agrees that this Contract shall be null and void if the Contractor is, or within the past six (6) months has been, an employee of the State of Tennessee or if the Contractor is an entity in which a controlling interest is held by an individual who is, or within the past six (6) months has been, an employee of the State of Tennessee.

D.9. Nondiscrimination. The Contractor hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the Contractor on the

grounds of handicap or disability, age, race, creed, color, religion, sex, national origin, or any other classification protected by federal or state law. The Contractor shall, upon request, show proof of nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

D.10. Prohibition of Illegal Immigrants. The requirements of Tenn. Code Ann. § 12-3-309 addressing the use of illegal immigrants in the performance of any contract to supply goods or services to the state of Tennessee, shall be a material provision of this Contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Contract.

a. The Contractor agrees that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document at Attachment A, semi-annually during the Term. If the Contractor is a party to more than one contract with the State, the Contractor may submit one attestation that applies to all contracts with the State. All Contractor attestations shall be maintained by the Contractor and made available to State officials upon request.

b. Prior to the use of any subcontractor in the performance of this Contract, and semi-annually thereafter, during the Term, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work under this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work under this Contract. Attestations obtained from subcontractors shall be maintained by the Contractor and made available to State officials upon request.

c. The Contractor shall maintain records for all personnel used in the performance of this Contract. Contractor's records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.

d. The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of Tenn. Code Ann. § 12-3-309 for acts or omissions occurring after its effective date.

e. For purposes of this Contract, "illegal immigrant" shall be defined as any person who is not: (i) a United States citizen; (ii) a Lawful Permanent Resident; (iii) a person whose physical presence in the United States is authorized; (iv) allowed by the federal Department of Homeland Security and who, under federal immigration laws or regulations, is authorized to be employed in the U.S.; or (v) is otherwise authorized to provide services under the Contract.

D.11. Records. The Contractor shall maintain documentation for all charges under this Contract. The books, records, and documents of the Contractor, for work performed or money received under this Contract, shall be maintained for a period of five (5) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.

D.12. Monitoring. The Contractor's activities conducted and records maintained pursuant to this Contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.

D.13. Progress Reports. The Contractor shall submit brief, periodic, progress reports to the State as requested.

D.14. Strict Performance. Failure by any Party to this Contract to require, in any one or more cases, the strict performance of any of the terms, covenants, conditions, or provisions of this Contract shall not be construed as a waiver or relinquishment of any term, covenant, condition, or provision. No term or condition of this Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the Parties.

D.15. Independent Contractor. The Parties shall not act as employees, partners, joint venturers, or associates of one another. The Parties are independent contracting entities. Nothing in this Contract shall be construed to create an employer/employee relationship or to allow either Party to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one Party are not employees or agents of the other Party.

D.16 Patient Protection and Affordable Care Act. The Contractor agrees that it will be responsible for compliance with the Patient Protection and Affordable Care Act ("PPACA") with respect to itself and its employees, including any obligation to report health insurance coverage, provide health insurance coverage, or pay any financial assessment, tax, or penalty for not providing health insurance. The Contractor shall indemnify the State and hold it harmless for any costs to the State arising from Contractor's failure to fulfill its PPACA responsibilities for itself or its employees.

D.17. Limitation of State's Liability. The State shall have no liability except as specifically provided in this Contract. In no event will the State be liable to the Contractor or any other party for any lost revenues, lost profits, loss of business, decrease in the value of any securities or cash position, time, goodwill, or any indirect, special, incidental, punitive, exemplary or consequential damages of any nature, whether based on warranty, contract, statute, regulation, tort (including but not limited to negligence), or any other legal theory that may arise under this Contract or otherwise. The State's total liability under this Contract (including any exhibits, schedules, amendments or other attachments to the Contract) or otherwise shall under no circumstances exceed the Maximum Liability. This limitation of liability is cumulative and not per incident.

D.18. Limitation of Contractor's Liability. In accordance with Tenn. Code Ann. § 12-3-701, the Contractor's liability for all claims arising under this Contract shall be limited to an amount equal to two (2) times the Maximum Liability amount detailed in Section C.1. and as may be amended, PROVIDED THAT in no event shall this Section limit the liability of the Contractor for: (i) intellectual property or any Contractor indemnity obligations for infringement for third-party intellectual property rights; (ii) any claims covered by any specific provision in the Contract providing for liquidated damages; or (iii) any claims for intentional torts, criminal acts, fraudulent conduct, or acts or omissions that result in personal injuries or death.

D.19. Hold Harmless. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Contractor, its employees, or any person acting for or on its or their behalf relating

to this Contract. The Contractor further agrees it shall be liable for the reasonable cost of attorneys for the State to enforce the terms of this Contract.

In the event of any suit or claim, the Parties shall give each other immediate notice and provide all necessary assistance to respond. The failure of the State to give notice shall only relieve the Contractor of its obligations under this Section to the extent that the Contractor can demonstrate actual prejudice arising from the failure to give notice. This Section shall not grant the Contractor, through its attorneys, the right to represent the State in any legal matter, as the right to represent the State is governed by Tenn. Code Ann. § 8-6-106.

D.20. HIPAA Compliance. The State and Contractor shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Health Information Technology for Economic and Clinical Health ("HITECH") Act and any other relevant laws and regulations regarding privacy (collectively the "Privacy Rules"). The obligations set forth in this Section shall survive the termination of this Contract.

a. Contractor warrants to the State that it is familiar with the requirements of the Privacy Rules, and will comply with all applicable requirements in the course of this Contract.

b. Contractor warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by the Privacy Rules, in the course of performance of the Contract so that both parties will be in compliance with the Privacy Rules.

c. The State and the Contractor will sign documents, including but not limited to business associate agreements (see Contract Attachment D), as required by the Privacy Rules and that are reasonably necessary to keep the State and Contractor in compliance with the Privacy Rules. This provision shall not apply if information received or delivered by the parties under this Contract is NOT "protected health information" as defined by the Privacy Rules, or if the Privacy Rules permit the parties to receive or deliver the information without entering into a business associate agreement or signing another document.

d. The Contractor will indemnify the State and hold it harmless for any violation by the Contractor or its subcontractors of the Privacy Rules. This includes the costs of responding to a breach of protected health information, the costs of responding to a government enforcement action related to the breach, and any fines, penalties, or damages paid by the State because of the violation.

e. The Contractor shall not sell Public Sector Plan Member information or use Member information unless it is aggregated blinded data, which is not identifiable on a Member basis. The State must approve, In Writing, the use of and sale of any of our member or plan data, even if being used in an aggregated, blinded data format.

f. The Contractor shall not use Public Sector Plan Member identified or non-aggregated information for advertising, marketing, promotion or any activity intended to influence sales or market share of any product or service except when permitted by the State, such as advertisements of the Program for enrollment purposes.

g. The Contractor shall have full financial responsibility for any penalties, fines, or other payments imposed or required as a result of the Contractor's non-compliance with or violation of HIPAA or HITECH requirements, and the Contractor shall indemnify the State with respect to any such penalties, fines, or payments, including the cost of credit protection. At the request of the State, the Contractor shall offer credit protection for those times in which a Member's PHI is accidentally or inappropriately disclosed.

D.21. Tennessee Consolidated Retirement System. Subject to statutory exceptions contained in Tenn. Code Ann. §§ 8-36-801, *et seq*., the law governing the Tennessee Consolidated Retirement System ("TCRS"), provides that if a retired member of TCRS, or of any superseded system administered by TCRS, or of any local retirement fund established under Tenn. Code Ann. §§ 8-35-101, *et seq.*, accepts State employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this Contract to the contrary, the Contractor agrees that if it is later determined that the true nature of the working relationship between the Contractor and the State under this Contract is that of "employee/employer" and not that of an independent contractor, the Contractor, if a retired member of TCRS, may be required to repay to TCRS the amount of retirement benefits the Contractor received from TCRS during the Term.

D.22. Tennessee Department of Revenue Registration. The Contractor shall comply with all applicable registration requirements contained in Tenn. Code Ann. §§ 67-6-601 – 608. Compliance with applicable registration requirements is a material requirement of this Contract.

D.23. Debarment and Suspension. The Contractor certifies, to the best of its knowledge and belief, that it, its current and future principals, its current and future subcontractors and their principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or agency;

b. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;

c. are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in section b. of this certification; and

d. have not within a three (3) year period preceding this Contract had one or more public transactions (federal, state, or local) terminated for cause or default.

The Contractor shall provide immediate written notice to the State if at any time it learns that there was an earlier failure to disclose information or that due to changed circumstances, its principals or the principals of its subcontractors are excluded, disqualified, or presently fall under any of the prohibitions of sections a-d.

D.24. Force Majeure. "Force Majeure Event" means fire, flood, earthquake, elements of nature or acts of God, wars, riots, civil disorders, rebellions or revolutions, acts of terrorism or any other similar cause beyond the reasonable control of the Party except to the extent that the non-performing Party is at fault in failing to prevent or causing the default or delay, and provided that the default or delay cannot reasonably be circumvented by the non-performing Party through the use of alternate sources, workaround plans or other means. A strike, lockout or labor dispute shall not

excuse either Party from its obligations under this Contract. Except as set forth in this Section, any failure or delay by a Party in the performance of its obligations under this Contract arising from a Force Majeure Event is not a default under this Contract or grounds for termination. The non-performing Party will be excused from performing those obligations directly affected by the Force Majeure Event, and only for as long as the Force Majeure Event continues, provided that the Party continues to use diligent, good faith efforts to resume performance without delay. The occurrence of a Force Majeure Event affecting Contractor's representatives, suppliers, subcontractors, customers or business apart from this Contract is not a Force Majeure Event under this Contract. Contractor will promptly notify the State of any delay caused by a Force Majeure Event (to be confirmed in a written notice to the State within one (1) day of the inception of the delay) that a Force Majeure Event has occurred, and will describe in reasonable detail the nature of the Force Majeure Event. If any Force Majeure Event results in a delay in Contractor's performance longer than forty-eight (48) hours, the State may, upon notice to Contractor: (a) cease payment of the fees until Contractor resumes performance of the affected obligations; or (b) immediately terminate this Contract or any purchase order, in whole or in part, without further payment except for fees then due and payable. Contractor will not increase its charges under this Contract or charge the State any fees other than those provided for in this Contract as the result of a Force Majeure Event.

D.25. State and Federal Compliance. The Contractor shall comply with all applicable state and federal laws and regulations in the performance of this Contract.

D.26. Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The Tennessee Claims Commission or the state or federal courts in Tennessee shall be the venue for all claims, disputes, or disagreements arising under this Contract. The Contractor acknowledges and agrees that any rights, claims, or remedies against the State of Tennessee or its employees arising under this Contract shall be subject to and limited to those rights and remedies available under Tenn. Code Ann. §§ 9-8-101 - 407.

D.27. Entire Agreement. This Contract is complete and contains the entire understanding between the Parties relating to its subject matter, including all the terms and conditions of the Parties' agreement. This Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the Parties, whether written or oral.

D.28. Severability. If any terms and conditions of this Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions of this Contract shall not be affected and shall remain in full force and effect. The terms and conditions of this Contract are severable.

D.29. Headings. Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.

D.30. Incorporation of Additional Documents. Each of the following documents is included as a part of this Contract by reference. In the event of a discrepancy or ambiguity regarding the Contractor's duties, responsibilities, and performance under this Contract, these items shall govern in order of precedence below:

a. any amendment to this Contract, with the latter in time controlling over any earlier amendments;

b. this Contract with any attachments or exhibits (excluding the items listed at subsections c. through f., below), which includes:

i. Contract Attachment A Attestation Re Personnel Used in Contract Performance;

ii. Contract Attachment B Performance Guarantees and Liquidated Damages;

iii. Contract Attachment C Reporting Requirements; and

iv. Contract Attachment D HIPAA Business Associate Agreement

c. any clarifications of or addenda to the Contractor's proposal seeking this Contract;

d. the State solicitation, as may be amended, requesting responses in competition for this Contract;

e. any technical specifications provided to proposers during the procurement process to award this Contract;

f. the Contractor's response seeking this Contract; and

g. any Contractor rules or policies including but not limited to internal rules, policies, and statements such as insurance policies filings by the Contractor with State regulators

D.31. Iran Divestment Act. The requirements of Tenn. Code Ann. § 12-12-101 et. seq., addressing contracting with persons as defined at T.C.A. §12-12-103(5) that engage in investment activities in Iran, shall be a material provision of this Contract. The Contractor certifies, under penalty of perjury, that to the best of its knowledge and belief that it is not on the list created pursuant to Tenn. Code Ann. § 12-12-106.

D.32. Insurance. Contractor shall maintain insurance coverage as specified in this Section. The State reserves the right to amend or require additional insurance coverage, coverage amounts, and endorsements required under this Contract. Contractor's failure to maintain or submit evidence of insurance coverage, as required, is a material breach of this Contract. If Contractor loses insurance coverage, fails to renew coverage, or for any reason becomes uninsured during the Term, Contractor shall immediately notify the State. All insurance companies providing coverage must be: (a) acceptable to the State; (b) authorized by the Tennessee Department of Commerce and Insurance ("TDCI"); and (c) rated A- / VII or better by A.M. Best. All coverage must be on a primary basis and noncontributory with any other insurance or self-insurance carried by the State. Contractor agrees to name the State as an additional insured on any insurance policy with the exception of workers' compensation (employer liability) and professional liability (errors and omissions) insurance. All policies must contain an endorsement for a waiver of subrogation in favor of the State. Any deductible or self insured retention ("SIR") over fifty thousand dollars ($50,000) must be approved by the State. The deductible or SIR and any premiums are the Contractor's sole responsibility. The Contractor agrees that the insurance requirements specified in this Section do not reduce any liability the Contractor has assumed under this Contract including any indemnification or hold harmless requirements.

To achieve the required coverage amounts, a combination of an otherwise deficient specific policy and an umbrella policy with an aggregate meeting or exceeding the required coverage amounts is acceptable. For example: If the required policy limit under this Contract is for two million dollars ($2,000,000) in coverage, acceptable coverage would include a specific policy covering one million dollars ($1,000,000) combined with an umbrella policy for an additional one million dollars ($1,000,000). If the deficient underlying policy is for a coverage area without aggregate limits (generally Automobile Liability and Employers' Liability Accident), Contractor shall provide a copy of the umbrella insurance policy documents to ensure that no aggregate limit applies to the umbrella policy for that coverage area. In the event that an umbrella policy is being provided to achieve any required coverage amounts, the umbrella policy shall be accompanied by an endorsement at least as broad as the Insurance Services Office, Inc. (also known as "ISO") "Noncontributory—Other Insurance Condition" endorsement or shall be written on a policy form that addresses both the primary and noncontributory basis of the umbrella policy if the State is otherwise named as an additional insured.

Contractor shall provide the State a certificate of insurance ("COI") evidencing the coverages and amounts specified in this Section. The COI must be on a form approved by the TDCI (standard

ACORD form preferred). The COI must list each insurer's National Association of Insurance Commissioners (NAIC) number and be signed by an authorized representative of the insurer. The COI must list the State of Tennessee – CPO Risk Manager, 312 Rosa L. Parks Ave., 3rd floor Central Procurement Office, Nashville, TN 37243 as the certificate holder. Contractor shall provide the COI ten (10) Business Days prior to the Effective Date and again thirty (30) calendar days before renewal or replacement of coverage. Contractor shall provide the State evidence that all subcontractors maintain the required insurance or that subcontractors are included under the Contractor's policy. At any time, the State may require Contractor to provide a valid COI. The parties agree that failure to provide evidence of insurance coverage as required is a material breach of this Contract. If Contractor self-insures, then a COI will not be required to prove coverage. Instead Contractor shall provide a certificate of self-insurance or a letter, on Contractor's letterhead, detailing its coverage, policy amounts, and proof of funds to reasonably cover such expenses. The State reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time.

The State agrees that it shall give written notice to the Contractor as soon as practicable after the State becomes aware of any claim asserted or made against the State, but in no event later than thirty (30) calendar days after the State becomes aware of such claim. The failure of the State to give notice shall only relieve the Contractor of its obligations under this Section to the extent that the Contractor can demonstrate actual prejudice arising from the failure to give notice. This Section shall not grant the Contractor or its insurer, through its attorneys, the right to represent the State in any legal matter, as the right to represent the State is governed by Tenn. Code Ann. § 8-6-106.

The Contractor shall obtain and maintain, at a minimum, the following insurance coverages and policy limits.

a. Commercial General Liability ("CGL") Insurance

    1) The Contractor shall maintain CGL, which shall be written on an ISO Form CG 00 01 occurrence form (or a substitute form providing equivalent coverage) and shall cover liability arising from property damage, premises and operations products and completed operations, bodily injury, personal and advertising injury, and liability assumed under an insured contract (including the tort liability of another assumed in a business contract).

       The Contractor shall maintain single limits not less than one million dollars ($1,000,000) per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this policy or location of occurrence or the general aggregate limit shall be twice the required occurrence limit.

a. Workers' Compensation and Employer Liability Insurance

    1) For Contractors statutorily required to carry workers' compensation and employer liability insurance, the Contractor shall maintain:

        i. Workers' compensation in an amount not less than one million dollars ($1,000,000) including employer liability of one million dollars ($1,000,000) per accident for bodily injury by accident, one million dollars ($1,000,000) policy limit by disease, and one million dollars ($1,000,000) per employee for bodily injury by disease.

2) If the Contractor certifies that it is exempt from the requirements of Tenn. Code Ann. § 50-6-101 – 103, then the Contractor shall furnish written proof of such exemption for one or more of the following reasons:

i. The Contractor employs fewer than five (5) employees;

ii. The Contractor is a sole proprietor;

iii. The Contractor is in the construction business or trades with no employees;

iv. The Contractor is in the coal mining industry with no employees;

v. The Contractor is a state or local government; or

vi. The Contractor self-insures its workers' compensation and is in compliance with the TDCI rules and Tenn. Code Ann. § 50-6-405.

b. Automobile Liability Insurance

1) The Contractor shall maintain automobile liability insurance which shall cover liability arising out of any automobile (including owned, leased, hired, and non-owned automobiles).

2) The Contractor shall maintain bodily injury/property damage with a limit not less than one million dollars ($1,000,000) per occurrence or combined single limit.

c. Professional Liability Insurance

1) Professional liability insurance shall be written on an occurrence basis or on a claims-made basis. If this coverage is written on a claims-made basis, then:

i. The retroactive date must be shown, and must be on or before the earlier of the Effective Date of the Contract or the beginning of Contract work or provision of goods and services;

ii. Insurance must be maintained and evidence of insurance must be provided for at least five (5) full years from the date of the final Contract payment; and

iii. If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a retroactive date on or prior to the Contract Effective Date, the Contractor must purchase "extended reporting" or "tail coverage" for a minimum of five (5) full years from the date of the final Contract payment.

2) Any professional liability insurance policy shall have a limit not less than one million dollars ($1,000,000) per claim and two million dollars ($2,000,000) in the aggregate; and

3) If the Contract involves the provision of services by medical professionals, a policy limit not less than three million ($3,000,000) per claim and three million dollars ($3,000,000) in the aggregate for medical malpractice insurance.

d. Technology Professional Liability (Errors & Omissions)/Cyber Liability Insurance

1) The Contractor shall maintain technology professional liability (errors & omissions)/cyber liability insurance appropriate to the Contractor's profession in an amount not less than five million dollars ($5,000,000) per occurrence or claim and five million dollars ($5,000,000) annual aggregate, covering all acts, errors, omissions, negligence, infringement of intellectual property (except patent and trade secret); network security and privacy risks, including but not limited to unauthorized access, failure of security, information theft, damage to destruction of or alteration of electronic information, breach of privacy perils, wrongful disclosure and release of private information, collection, or other negligence in the handling of confidential information, and including coverage for related regulatory fines, defenses, and penalties.

2) Such coverage shall include data breach response expenses, in an amount not less than five million dollars ($5,000,000) and payable whether incurred by the State or Contractor, including but not limited to consumer notification, whether or not required by law, computer forensic investigations, public relations and crisis management firm fees, credit file or identity monitoring or remediation services and expenses in the performance of services for the State or on behalf of the State hereunder.

D.33. Major Procurement Contract Sales and Use Tax. Pursuant to Tenn. Code Ann. § 4-39-102 and to the extent applicable, the Contractor and the Contractor's Subcontractors shall remit sales and use taxes on the sales of goods or services that are made by the Contractor or the Contractor's Subcontractors and that are subject to tax.

E. SPECIAL TERMS AND CONDITIONS:

E.1. Conflicting Terms and Conditions. Should any of these special terms and conditions conflict with any other terms and conditions of this Contract, the special terms and conditions shall be subordinate to the Contract's other terms and conditions.

E.2. Confidentiality of Records. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State that is regarded as confidential under state or federal law shall be regarded as "Confidential Information." Nothing in this Section shall permit Contractor to disclose any Confidential Information, regardless of whether it has been disclosed or made available to the Contractor due to intentional or negligent actions or inactions of agents of the State or third parties. Confidential Information shall not be disclosed except as required or permitted under state or federal law. Contractor shall take all necessary steps to safeguard the confidentiality of such material or information in conformance with applicable state and federal law.

The obligations set forth in this Section shall survive the termination of this Contract.

E.3. Software License Warranty. Contractor grants a license to the State to use all software provided under this Contract in the course of the State's business and purposes.

E.4. Software Support and Maintenance Warranty. Contractor shall provide to the State all software upgrades, modifications, bug fixes, or other improvements in its software that it makes generally available to its customers.

E.5. Prohibited Advertising or Marketing. The Contractor shall not suggest or imply in advertising or marketing materials that Contractor's goods or services are endorsed by the State. The restrictions on Contractor advertising or marketing materials under this Section shall survive the termination of this Contract.

E.6. Contractor Commitment to Diversity. The Contractor shall comply with and make reasonable business efforts to exceed the commitment to diversity represented by the Contractor's Response to #31786-00143 (RFP Attachment 6.2 Section B.15) and resulting in this Contract.

The Contractor shall assist the State in monitoring the Contractor's performance of this commitment by providing, as requested, a monthly report of participation in the performance of this Contract by small business enterprises and businesses owned by minorities, women, service-disabled veterans, and persons with disabilities. Such reports shall be provided to the State of Tennessee Governor's Office of Diversity Business Enterprise in the TN Diversity Software available online at: https://tn.diversitysoftware.com/FrontEnd/StartCertification.asp?TN=tn&XID=9810.

E.7. Liquidated Damages. If the Contractor fails to perform in accordance with any term or provision of this contract, only provides partial performance of any term or provision of the Contract, violates any warranty, or any act prohibited or restricted by the Contract occurs, ("Liquidated Damages Event"), the State may assess damages on Contractor ("Liquidated Damages"). The State shall notify the Contractor of amounts to be assessed as Liquidated Damages. The Parties agree that due to the complicated nature of the Contractor's obligations under this Contract it would be difficult to specifically designate a monetary amount for Contractor's failure to fulfill its obligations regarding the Liquidated Damages Event as these amounts are likely to be uncertain and not easily proven. Contractor has carefully reviewed the Liquidated Damages contained in Attachment B and agrees that these amounts represent a reasonable relationship between the amount and what might reasonably be expected in the event of a Liquidated Damages Event, and are a reasonable estimate of the damages that would occur from a Liquidated Damages Event. The Parties agree that the Liquidated Damages represent solely the damages and injuries sustained by the State in losing the benefit of the bargain with Contractor and do not include any injury or damage sustained by a third party. The Contractor agrees that the Liquidated Damages are in addition to any amounts Contractor may owe the State pursuant to the indemnity provision or any other sections of this Contract.

The State is not obligated to assess Liquidated Damages before availing itself of any other remedy. The State may choose to discontinue Liquidated Damages and avail itself of any other remedy available under this Contract or at law or equity.

E.8. Personally Identifiable Information. While performing its obligations under this Contract, Contractor may have access to Personally Identifiable Information held by the State ("PII"). For the purposes of this Contract, "PII" includes "Nonpublic Personal Information" as that term is defined in Title V of the Gramm-Leach-Bliley Act of 1999 or any successor federal statute, and the rules and regulations thereunder, all as may be amended or supplemented from time to time ("GLBA") and personally identifiable information and other data protected under any other applicable laws, rule or regulation of any jurisdiction relating to disclosure or use of personal information ("Privacy Laws"). Contractor agrees it shall not do or omit to do anything which would cause the State to be in breach of any Privacy Laws. Contractor shall, and shall cause its employees, agents and representatives to: (i) keep PII confidential and may use and disclose PII only as necessary to carry out those specific aspects of the purpose for which the PII was disclosed to Contractor and in accordance with this Contract, GLBA and Privacy Laws; and (ii) implement and maintain appropriate technical and organizational measures regarding information security to: (A) ensure the security and confidentiality of PII; (B) protect against any threats or

hazards to the security or integrity of PII; and (C) prevent unauthorized access to or use of PII. Contractor shall immediately notify State: (1) of any disclosure or use of any PII by Contractor or any of its employees, agents and representatives in breach of this Contract; and (2) of any disclosure of any PII to Contractor or its employees, agents and representatives where the purpose of such disclosure is not known to Contractor or its employees, agents and representatives. The State reserves the right to review Contractor's policies and procedures used to maintain the security and confidentiality of PII and Contractor shall, and cause its employees, agents and representatives to, comply with all reasonable requests or directions from the State to enable the State to verify and/or procure that Contractor is in full compliance with its obligations under this Contract in relation to PII. Upon termination or expiration of the Contract or at the State's direction at any time in its sole discretion, whichever is earlier, Contractor shall immediately return to the State any and all PII which it has received under this Contract and shall destroy all records of such PII.

The Contractor shall report to the State any instances of unauthorized access to or potential disclosure of PII in the custody or control of Contractor ("Unauthorized Disclosure") that come to the Contractor's attention. Any such report shall be made by the Contractor within twenty-four (24) hours after the Unauthorized Disclosure has come to the attention of the Contractor. Contractor shall take all necessary measures to halt any further Unauthorized Disclosures. The Contractor, at the sole discretion of the State, shall provide no cost credit monitoring services for individuals whose PII was affected by the Unauthorized Disclosure. The Contractor shall bear the cost of notification to all individuals affected by the Unauthorized Disclosure, including individual letters and public notice. The remedies set forth in this Section are not exclusive and are in addition to any claims or remedies available to this State under this Contract or otherwise available at law.

E.9. Contractor Hosted Services and Confidential Data.

a. "Confidential State Data" is defined as data deemed confidential by State or Federal statute or regulation. The Contractor shall protect Confidential State Data as follows:

(1) The Contractor shall ensure that all Confidential State Data is housed in the continental United States, inclusive of backup data.

(2) The Contractor shall encrypt Confidential State Data at rest and in transit using the current version of Federal Information Processing Standard ("FIPS") 140-2 validated encryption technologies.

(3) The Contractor's processing environment containing Confidential State Data shall be in accordance with at least one of the following security standards: (i) International Standards Organization ("ISO") 27001; (ii) Federal Risk and Authorization Management Program ("FedRAMP"); or (iii) American Institute of Certified Public Accountants ("AICPA") Service Organization Controls ("SOC") 2 Type II certified. The Contractor shall provide proof of current certification annually and upon State request. The Contractor shall also provide, at the State's request, a copy of the report for any applicable Subcontractors.

(4) The Contractor must comply with the State's Enterprise Information Security Policies. This document is found at the following URL: https://www.tn.gov/content/dam/tn/finance/documents/Enterprise-Information-Security-Policies-v2-3-ISO-27002-12-21-2018-Public-FINAL-with-Sigs.pdf

(5) In the event that the operating system is an integral part of the application, the Contractor agrees to maintain Operating Systems at current, manufacturer supported versions. “Operating System” shall mean the software that supports a computer's basic functions, such as scheduling tasks, executing applications, and controlling peripherals.

(6) The Contractor agrees to maintain the Application so that it will run on a current, manufacturer-supported Operating System. “Application” shall mean the computer code that supports and accomplishes the State’s requirements as set forth in this Contract. The Contractor shall make sure that the Application is at all times fully compatible with a manufacturer-supported Operating System; the State shall not be required to run an Operating System that is no longer supported by the manufacturer.

(7) If the Application requires middleware or database software, Contractor shall maintain middleware and database software versions that are at all times fully compatible with current versions of the Operating System and Application, to ensure that security vulnerabilities are not introduced.

(8) With advance notice from the State, and no more than one (1) time per year the Contractor agrees to allow the State to perform logical and physical audits of the Contractor’s facility and systems that are hosting Confidential State Data.

(9) The Contractor must annually perform Penetration Tests and Vulnerability Assessments against its Processing Environment. “Processing Environment” shall mean the combination of software and hardware on which the Application runs. “Penetration Tests” shall be in the form of software attacks on the Contractor’s computer system, with the purpose of discovering security weaknesses, and potentially gaining access to the computer's features and data. The “Vulnerability Assessment” shall have the goal of defining, identifying, and classifying the security holes (vulnerabilities) in the Contractor’s computer, network, or communications infrastructure. Subject to mutually agreed upon protocols, the Contractor shall allow the State to utilize a mutually agreeable and accredited third party, to perform Penetration Tests and Vulnerability Assessments on the Contractor's Processing Environment once per year.

b. Business Continuity Requirements.

(1) Regardless of the architecture of its systems, the Contractor shall develop and be continually ready to invoke a business continuity and Disaster recovery (“BC-DR”) plan. The BC-DR plan shall encompass all Information Systems supporting this Contract. At a minimum the Contractor’s BC-DR plan shall address and provide the results for the following scenarios:

i. Central and/or satellite data processing, telecommunications, print and mailing facilities and functions therein, hardware and software are destroyed or damaged;
ii. System interruption or failure resulting from network, operating hardware, software, communications infrastructure or operational errors that

compromise the integrity of transactions that are active in a live system at the time of the outage;

iii. System interruption or failure resulting from network, operating hardware, software, communications infrastructure or operational errors that compromise the integrity of data maintained in a live or archival system; and

iv. System interruption or failure resulting from network, operating hardware, software, communications infrastructure or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the system.

(2) The Contractor shall maintain set(s) of documents, instructions, and procedures which enable the Contractor to respond to accidents, Disasters, emergencies, or threats without any stoppage or hindrance in its key operations ("Business Continuity Requirements"). Business Continuity Requirements shall include:

i. "Disaster Recovery Capabilities" refer to the actions the Contractor takes to meet the Recovery Point and Recovery Time Objectives defined below. Disaster Recovery Capabilities shall meet the following objectives:

a. Recovery Point Objective ("RPO"). The RPO is defined as the maximum targeted period in which data might be lost from an IT service due to a major incident. The maximum RPO acceptable to the State is one (1) hour.

b. Recovery Time Objective ("RTO"). The RTO is defined as the targeted duration of time and a service level within which a business process must be restored after a Disaster (or disruption) in order to avoid unacceptable consequences associated with a break in business continuity: Seventy-two (72) hours.

ii. The Contractor shall perform at least one Disaster Recovery Test every three hundred sixty-five (365) days. A "Disaster Recovery Test" shall mean the process of verifying the success of the restoration procedures that are executed after a critical IT failure or disruption occurs. The Disaster Recovery Test shall use actual State Data Sets that mirror production data, and success shall be defined as the Contractor verifying that the Contractor can meet the State's RPO and RTO requirements. A "Data Set" is defined as a collection of related sets of information that is composed of separate elements but can be manipulated as a unit by a computer. The Contractor shall provide written confirmation to the State after each Disaster Recover Test that its Disaster Recovery Capabilities meet the RPO and RTO requirements. The Contractor shall submit a written summary of its annual BC-DR test results to the State (see Contract Attachment C #2).

c. Upon State request, the Contractor shall provide a copy of all Confidential State Data it holds. The Contractor shall provide such data on media and in a format determined by the State.

The Contractor shall maintain a duplicate set of all records relating to this Contract in electronic medium, usable by the State and the Contractor for the purpose of Disaster recovery. Such duplicate records are to be stored at a secure fire, flood, and theft-protected facility located away from the storage location of the originals. The Contractor shall update duplicate records, at a minimum, on a daily basis and shall retain said records for a period of sixty (60) days from the date of creation.

d. Upon termination of this Contract or upon notice of termination of this Contract prior to the Term date, the Contractor shall convey the original and the duplicate records medium and the information they contain to the State on or before the date of termination. In consultation with the State, the Contractor shall destroy all Confidential State Data it holds (including any copies such as backups) in accordance with the current version of National Institute of Standards and Technology ("NIST") Special Publication 800-88. The Contractor shall provide a written confirmation of destruction to the State within ten (10) Business Days after destruction.

E.10. Intellectual Property Indemnity. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims or suits which may be brought against the State concerning or arising out of any claim of an alleged patent, copyright, trade secret or other intellectual property infringement. In any such claim or action brought against the State, the Contractor shall satisfy and indemnify the State for the amount of any settlement or final judgment, and the Contractor shall be responsible for all legal or other fees or expenses incurred by the State arising from any such claim. The State shall give the Contractor notice of any such claim or suit, however, the failure of the State to give such notice shall only relieve Contractor of its obligations under this Section to the extent Contractor can demonstrate actual prejudice arising from the State's failure to give notice. This Section shall not grant the Contractor, through its attorneys, the right to represent the State of Tennessee in any legal matter, as provided in Tenn. Code Ann. § 8-6-106.

E. 11. Extraneous Terms and Conditions. Contractor shall fill all orders submitted by the State under this Contract. No purchase order, invoice, or other documents associated with any sales, orders, or supply of any good or service under this Contract shall contain any terms or conditions other than as set forth in the Contract. Any such extraneous terms and conditions shall be void, invalid and unenforceable against the State. Any refusal by Contractor to supply any goods or services under this Contract conditioned upon the State submitting to any extraneous terms and conditions shall be a material breach of the Contract and constitute an act of bad faith by Contractor.

E.12. Survival. The terms, provisions, representations, and warranties contained in this Contract which by their sense and context are intended to survive the performance and termination of this Contract, shall so survive the completion of performance and termination of this Contract.

IN WITNESS WHEREOF,

CONTRACTOR LEGAL ENTITY NAME:

CONTRACTOR SIGNATURE **DATE**

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

STATE OF TENNESSEE,
STATE INSURANCE COMMITTEE,
LOCAL EDUCATION INSURANCE COMMITTEE,
LOCAL GOVERNMENT INSURANCE COMMITTEE:

Larry B. Martin, CHAIRMAN **DATE**

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	
CONTRACTOR LEGAL ENTITY NAME:	
EDISON VENDOR IDENTIFICATION NUMBER:	

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any Subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract.

CONTRACTOR SIGNATURE

NOTICE: This attestation MUST be signed by an individual empowered to contractually bind the Contractor. Attach evidence documenting the individual's authority to contractually bind the Contractor, unless the signatory is the Contractor's chief executive or president.

PRINTED NAME AND TITLE OF SIGNATORY

DATE OF ATTESTATION

LIQUIDATED DAMAGES

To effectively manage contractual performance, the State has established Liquidated Damages associated with Contractor's obligations with respect to the Contract. The Contractor is expected to perform according to a certain level of standards. If these standards are not met, the State is entitled to impose liquidated damage assessments. Damages are included in this Attachment.

The Parties agree that the Liquidated Damages represent solely the anticipated damages and injuries sustained by the State in losing the benefit of the bargain with Contractor and do not include any injury or damage sustained by a third party.

Payment of Liquidated Damages: It is agreed by the State and the Contractor that any liquidated damages assessed by the State shall be due and payable to the State within forty-five (45) calendar days after Contractor receipt of the Invoice containing an assessment of Liquidated Damages. If payment is not made by the due date, the Liquidated Damages amount may be withheld from future payments by the State without further notice.

1. Program Go-Live Date	
Guarantee	The pharmacy benefit for the Plans shall take effect and be fully Operational on the go-live date specified in Contract Section A.30. "Operational" is defined as the ability to accurately enroll Members, accept and process POS claims, accept and process Mail Order Service prescriptions, and provide all other PBM services outlined in the Contract.
Assessment	Twenty-five thousand dollars ($25,000) for each Business Day beyond the go live date that the program is not operational up to thirty (30) Business Days.
Justification	Program go-live is an imperative performance guarantee listed in the Contract. If there is a delay in this, the State is unable to provide pharmacy benefits coverage to our Members. This assessment and amount takes into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Assessed, reported, and reconciled no later than three (3) months after go-live date.
2. Implementation Plan	
Guarantee	The Contractor shall provide a project implementation plan, as required in Contract Section A.4, to the State no later than thirty (30) days after contract effective date, which includes all tasks with deliverable dates necessary to install the program by the go-live date.
Assessment	One thousand dollars ($1,000) for each Business Day beyond the deadline up to go-live date specified in Contract Section A.30.
Justification	This is a critical portion of the implementation of a new contract and needed before starting implementation to ensure all aspects of implementation are enacted accurately and timely. This assessment calculates the potential impact of missed or inaccurate implementation milestones.
Measurement	Assessed, reported, and reconciled no later than three (3) months after go-live date.
3. Operational Readiness	
Guarantee	The Contractor shall resolve all noncompliance with contract terms identified by

	the State during its operational readiness review including all milestones required in Contract Section A.4.g, prior to go-live date.
Assessment	Ten thousand dollars ($10,000) if any findings are not resolved prior to go-live.
Justification	Operational readiness review requires the Contractor and the State to investigate and navigate any potential issues, deadlines, and milestones leading up to go-live and operations.
Measurement	Assessed and reported no later than three (3) months after go-live date.
4. Plan Design	
Guarantee	Plan design per written communications with Benefits Administration (including covered services, excluded services, Member cost share, and ingredient cost pricing) will be implemented correctly, as required in Contract Section A.4.
Assessment	Twenty-five thousand dollars ($25,000) per incorrect plan design setup such as, but not limited to, incorrect member cost share, incorrect covered services or excluded services.
Justification	Plan design information must be timely and accurate as to not cause confusion or financial hardship to Members. This assessment and amount takes into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Assessed and reported three (3) months after go-live date and each successive plan year.
5. Eligibility Set-Up	
Guarantee	As required in Contract Section A.18.c, eligibility information must be loaded, tested, verified and available online for use no later than thirty (30) days prior to the go-live date specified in Contract Section A.30.
Assessment	Ten thousand dollars ($10,000) for each Business Day beyond the date specified in Contract Section A.18.c. up to the go-live date.
Justification	Eligibility set-up is a critical step in providing Members pharmacy benefits. Without the accurate and timely set-up of this file, there is a potential harm to Members financially and in receiving prescription medication. This assessment and amount takes into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Assessed, reported, and reconciled no later than three (3) months after go-live date.
6. Key Staff Vacancies	
Guarantee	As required in Contract Section A.5.k, if any Key Staff become vacant, the Contractor shall employ an adequate replacement within sixty (60) days of the vacancy unless the State grants an exception to this requirement.
Assessment	One-thousand dollars ($1,000) for exceeding the sixty (60) day requirement.
Justification	With a vacancy in our Contractor team, the State must have the ability to know when a replacement will be hired and ready to fulfill the Contract obligations. Without Key Staff, the State does not have the ability to contact the Contractor with Member issues to seek timely resolution. This assessment and amount takes into account the increased State staff time as a result of not having Key Staff in place.
Measurement	Assessed, reported, and reconciled quarterly.
7. Network Access	
Guarantee	As required in Contract Section A.8.e.1, the Contractor shall maintain a network of pharmacy providers to provide the covered services that met the following access standards using a GeoNetworks®, Quest, or comparable report:

	Access standard	Percentage	Measure
	Urban area	at least ninety percent (90%) of Members	Member(s) live within one and one-half (1.5) miles of a Retail Pharmacy participating in the Contractor's network
	Suburban area	at least ninety percent (90%) of Members	Member(s) live within three (3) miles of a Retail Pharmacy participating in the Contractor's network
	Rural area	at least ninety percent (90%) of Members	Member(s) live within ten (10) miles of a Retail Pharmacy participating in the Contractor's network
Assessment	Fifty thousand dollars ($50,000) if any of the access standards listed above are not met.		
Justification	The Contract requires minimum access standards and without those, Members do not have access to pharmacies within the access standards and therefore the potential to go without prescription medication and increased financial hardship. This assessment and amount takes into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.		
Measurement	Assessed, reported and reconciled annually using the GeoNetworks®, Quest, or comparable report provided by the Contractor.		
8. Claims Data Submission			
Guarantee	The Contractor shall submit claims data to the State's DSS contractor no later than fifteen (15) days following the end of each month, or more frequently as approved by the State, as required in Contract Section A.19.d.1-7		
Assessment	Five thousand dollars ($5,000) per Business Day up to the twentieth (20th) Business Day.		
Justification	Timely submission of claims data ensures that the State and Members have accurate and timely information. The State relies on the claims data information for reporting and planning purposes. Members rely on this data for Plan information such as deducible and out of pocket maximum amounts. This assessment and amount takes into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.		
Measurement	Assessed, reported and reconciled quarterly.		
9. Data Transmission to Third Party Contractors			
Guarantee	Unless otherwise directed by the State, the Contractor shall provide daily accumulator data feeds to the State's third party contractors listed in Contract Section A.19.g. until all claims incurred during the Term have been paid.		
Assessment	One thousand dollars ($1,000) for each daily data feed not provided.		
Justification	Data submissions to the State's third party contractors are critical for ongoing medical care and treatment for Members. This assessment and amount takes into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.		
Measurement	Assessed, reported and reconciled quarterly.		
10. Splash page			

Guarantee	The Contractor's splash page shall be available on the internet, fully operational and updated annually no later two (2) weeks prior to the State's annual open enrollment period, as required in Contract Sections A.24.d and A.24.f.
Assessment	One thousand dollars ($1,000) per Business Day until operational or updated.
Justification	This assessment and amount takes into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Assessed, reported, and reconciled annually.
11. Member Satisfaction Survey	
Guarantee	Approved Member Satisfaction survey(s) as required in Contract Section A.26, must have an overall customer satisfaction rating equal to or greater than eighty-five percent (85%) in the first year, and ninety percent (90%) in all subsequent year(s) within the Term.
Assessment	Twenty thousand dollars ($20,000) for each year that the standard is not met.
Justification	This assessment and amount takes into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Assessed, reported, and reconciled annually.
12. URAC Accreditation	
Guarantee	As required in Contract Section A.3.d, the Contractor shall possess and maintain full Pharmacy Benefit Management accreditation status with URAC during the entire term of this contract.
Assessment	Twenty thousand dollars ($20,000) per incurrence the accreditation is not maintained.
Justification	This accreditation sets out minimum standards and measurement that a Contractor must meet to receive URAC accreditation. This assessment and amount takes into account the State's increased oversite and management of the Contractor without this accreditation.
Measurement	Assessed, reported, and reconciled annually.
13. Reporting	
Guarantee	The Contractor shall distribute to the State all reports required in Contract Sections A.1 through A.30 within the time frame specified in the Contract.
Assessment	One thousand dollars ($1,000) for each report not delivered to the State within the time frame specified in the contract.
Justification	The State relies on reporting in making sure operations, services, KPIs, and desired outcomes provided by the Contractor. These are reported to our contract compliance and program director, reviewed and assessed, if applicable. The data provided in required reports is the foundation for future Plan design and decisions made by the State.
Measurement	Assessed, reported, and reconciled quarterly.
14. Unauthorized Usage of Information	
Guarantee	Unless prior approved In Writing by the State, and in compliance with state and federal law, the Contractor shall not use information gained through this Contract, including but not limited to utilization and pricing information, in marketing or expanding non-State business relationships or for any pecuniary gain.
Assessment	One hundred dollars ($100) per impacted Member unless that cannot be determined in which case the assessment shall be one hundred dollars ($100) per head of contract.
Justification	The State has a responsibility to protect Member information. The Contractor shall not use our Member information for pecuniary gain and the Contractor attested to this during the procurement process. This scenario causes confusion and potential harm to Members if they enroll in incorrect pharmacy

	benefit plans because of the Contractor's actions.
Measurement	Assessed, reported, reconciled upon identification of occurrence.
15. Privacy and Security of Protected Health Information Impacting 1 to 499 Members	
Guarantee	In accordance with Contract Section D.20 and Contract Attachment C, the Contractor shall not violate the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act). Pursuant to 45 CFR 164.402, breach is defined as the acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of the Privacy Rule which compromises the security or privacy of the PHI.
Justification	The guarantee and assessment estimates the impact on the State including the unpredictability of the timing of a breach; specifics of the breach's scope; length of time of investigation completion; number of Member calls to the BA service center; and level of legislative inquiries.
Assessment	Four Thousand Eight Hundred dollars ($4,800) per incident basis. This assessment is based on the previous experience BA has had in responding to similar incidents impacting less than five hundred (500) Members which includes the following predicted costs to BA: 1. HIPAA Compliance Officer time including investigating the breach, monitoring the HIPAA privacy hotline and email address estimated at seventy-five (75) hours; 2. Director of Financial Management and Program Integrity time and work estimated at seven and half (7.5) hours; 3. Program Director associated with this contract time and work estimated at fifteen (15) hours; 4. Executive Director's time and work estimated at one (1) hour; 5. Department attorney time including legal review estimated at one (1) hour; and 6. Service Center staff time and work answering Member questions/concerns estimated at fifteen (15) hours.
Measurement	Assessed, reported, assessed, and paid after each occurrence.
16. Privacy and Security of Protected Health Information Impacting 500 or more Members	
Guarantee	In accordance with Contract Section D.20 and Contract Attachment C, the Contractor shall not violate the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act). Pursuant to 45 CFR 164.402, breach is defined as the acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of the Privacy Rule which compromises the security or privacy of the PHI.
Justification	The guarantee and assessment estimates the impact on the State including the unpredictability of the timing of a breach; specifics of the breach's scope; length of time of investigation completion; number of Member calls to the BA service center; and level of legislative inquiries.

	A breach impacting five hundred (500) or more Members has additional required steps and procedures including notification to the Office of Civil Rights ("OCR") with the U.S. Department of Health & Human Services ("HSS"); documentation to OCR for a required investigation; the drafting and mailing of Member notification letters; and a federally-required media release to media outlets across the State.
Assessment	Nineteen Thousand dollars ($19,000) per incident basis. This assessment is based on the previous experience BA has had in responding to similar incidents impacting five hundred (500) or more Members which includes the following predicted costs to BA: 1. HIPAA Compliance Officer time including investigating the breach, monitoring the HIPAA privacy hotline and email address estimated at one hundred thirty(130) hours; 2. Director of Financial Management and Program Integrity time and work estimated at thirty (30) hours; 3. Program Director associated with this Contract time and work estimated at forty-five (45) hours; 4. Executive Director's time and work estimated at eighteen (18) hours; 5. Department attorney time including legal review estimated at thirty (30) hours; 6. Service Center staff time and work answering Member questions/concerns estimated at one-hundred (100) hours; 7. Public Information Officer ("PIO")'s time and work estimated at forty-five (45) hours; and 8. Communications Director's time and work estimated at thirty (30) hours.
Measurement	Assessed, reported, assessed, and paid after each occurrence.

REPORTING REQUIREMENTS

As required by this Contract, the Contractor shall submit reports to the State. Reports shall be submitted electronically, in the format approved by the State, and shall be of the type and at the frequency indicated below. The State reserves the right to modify reporting requirements as deemed necessary to monitor contract implementation. The State will provide the Contractor with at least sixty (60) days' notice prior to implementation of a report modification.

Unless otherwise directed by the State, the Contractor shall submit reports as follows:

a. Monthly reports shall be submitted by the 15th of the following month;

b. Quarterly reports shall be submitted by the 20th of the following month; and

c. Annual reports shall be submitted within ninety (90) days after the end of the calendar year.

Reports shall include, at a minimum (not an all-inclusive list; refer to contract for all specifics):

1. **Account Team Satisfaction Survey**, submitted annually in January.
2. **Business Continuity/Disaster Recovery results,** December 1, 2019 and annually thereafter
3. **Network Access Report**, submitted annually in January.
4. **Quarterly Network Changes Report,** submitted within five (5) Business days of the end of each calendar quarter after go-live date.
5. **Formulary Compliance Report,** submitted quarterly after go-live date.
6. **Therapeutic substitution and Generic Drug dispensing program report,** submitted annually in January.
7. **Prior Authorization (PA) reporting,** submitted quarterly after go-live date.
8. **Rebate and Administrative Fee reporting,** submitted quarterly after go-live date.
9. **Rebate Annual Reconciliation,** submitted during the first quarter of each calendar year.
10. **Financial Reporting,** quarterly at the end of each calendar quarter and annually during the first calendar quarter showing Contractor's financial targets (e.g. AWP minus %, Dispensing Fees, etc.) and outcomes.
11. **Operational/Performance Reporting,** monthly within fifteen (15) days of the end of the previous month.
12. **Compliance Report (aka report card),** submitted each calendar quarter showing for the previous quarter the Contractor's outcome for each of the measurements in the Contract Attachment B of this Contract, as well as any payment amount due for that quarter (if applicable).

13. **Rebate Payments report,** submitted at least sixty (60) days following the end of each calendar quarter after go-live date.

14. **FedRamp, ISO 27000 or SOC2 Type II report,** submitted within thirty (30) days of the Effective Date, annually thereafter, and in addition to periodic bridge reports as requested by the State.

15. **Pass Through Pricing Report,** submitted quarterly after go-live date as referenced in Contract Section A.7.c.

16. **Other Reports,** as specified in this Contract and using templates prior approved In Writing by the State.

17. **Specialty Drug List Additions and Deletions Report**, submitted by the 20th of the following month after each calendar quarter, after go-live date as referenced in Contract Section A.9.j(10).

Service Level Agreement Scorecard

Below is the SLA Scorecard and associated KPIs used to measure the Contractor's performance against the desired outcomes. Evaluated, scored, and reconciled quarterly via the SLA Scorecard with relevant documentation. Contractor must submit the SLA Scorecard each calendar quarter documenting the Contractor's outcome for each of the KPI for the previous quarter, in which services were delivered, as well as any At-Risk Performance Payment due (if applicable).

It is agreed by the State and the Contractor that any At-Risk Performance Payment assessed by the State shall be due and payable to the State within forty-five (45) calendar days after Contractor receipt of the Invoice containing an assessment of fees at risk. If payment is not made by the due date, the At-Risk Performance Payment amount may be withheld from future payments by the State without further notice.

KPI		Description	Performance Requirement	Vendor Performance	Score if Met	Quarterly Score
1.	POS System Availability	POS system, used by contracted pharmacies to process pharmacy claims, as required in Contract Section A.6.l, shall be accessible and operational ninety-nine point five percent (99.5%) of the time.	99.50%	99.5% or greater 98.0-99.4% 96.0-97.9% Less than 96%	9 6 3 0	
2.	POS System Processing	As required in Contract Section A.6.d, the Contractor shall process ninety-nine and a half percent (99.5%) of POS claims on a daily basis within five (5) seconds.	99.50%	99.5% or greater 98.0-99.4% 96.0-97.9% Less than 96%	5 3 1 0	
3.	Claims Processing Accuracy	Claims processing accuracy, as required in Contract Section A.6.k, shall be ninety-eight percent (98%) or higher.	98%	98% or greater 96.0-97.9% 94.0-95.9% Less than 94%	6 4 2 0	

4.	Claims Payment Accuracy	Claims payment accuracy, as required in Contract Section A.7.e, shall be ninety-nine percent (99%) or higher.	99%	99% or greater 97.0-98.9% 95.0-96.9% Less than 95%	6 4 2 0	
5.	Claims Payment Turnaround	As required in Contract Section A.7.h, ninety-six percent (96%) of direct reimbursement Clean Claims (either electronically through POS or through Member submitted paper claims) shall be paid within the lesser of fourteen (14) days or the contracted turnaround time with the pharmacy.	96%	96% 94.0-95.9% 92.0-93.9% Less than 92%	6 4 2 0	
6.	Generic Drug Substitution - Mail Order	As required in Contract Section A.9.j.1, ninety-five percent (95%) or more of Mail Order Service prescriptions for Multi-source drugs shall be dispensed with a Generic Drug product.	95%	95% or greater 93.0-94.9% 91.0-92.9% Less than 91%	6 4 2 0	
7.	Generic Drug Substitution - Retail	As required in Contract Section A.9.j.1, ninety percent (90%) or more of retail prescriptions for Multi-source drugs shall be dispensed with a Generic Drug product.	90%	90% or greater 88.0-89.9% 86.0-87.9% Less than 86%	8 4 2 0	
8.	PA Evaluation	As required in Contract Section A.12.h(4), the Contractor's PA staff shall evaluate ninety-nine percent (99%) of PA requests within twenty-four (24) hours.	99%	99% or greater 97.0-98.9% 95.0-96.9% Less than 95%	6 4 2 0	

9.	Eligibility Discrepancies	Resolve all discrepancies (any difference of values between the State's database and the Contractor's database) identified by the processing of the enrollment file within one (1) business day of identification, as required in Contract Section A.19.a.3.	100%	100% 98.0-99.9% 96.0-97.9% Less than 96%	6 5 4 0	
10.	Pre-Service Appeals	Ninety-five percent (95%) of Pre-Service Appeals shall be decided within thirty (30) days, as required in Contract Section A.21.c.	95%	95% or greater 93.0-94.9% 91.0-92.9% Less than 91%	4 3 2 0	
11.	Post-Service Appeals	Ninety-five percent (95%) of Post-Service Appeals within sixty (60) days, as required in Contract Section A.21.c.	95%	95% or greater 93.0-94.9% 91.0-92.9% Less than 91%	4 3 2 0	
12.	Telephone Coverage	The Contractor shall provide uninterrupted telephone coverage for twenty-four (24) hours a day/seven (7) days a week for claims, systems and customer service and pharmacy provider inquiries, as required in Contract Section A.22.a. Excluded from this are contracted-planned down times or Force Majeure Events as listed in Contract Section D.24.	100%	100% 98.0-99.9% 96.0-97.9% Less than 96%	8 6 4 0	
13.	Average Speed of Answer	The Contractor shall maintain an ASA of thirty (30) seconds and callers may not be placed on hold after the call is answered, as required in Contract Section A.22.j.	30 second average	30 Sec Avg 30.1-30.9 Sec Avg 31-30. Sec Avg Greater than 31 Sec Avg	8 6 4 0	

14.	Member Communications	All materials, including but not limited to: ID cards and letters produced by the Contractor shall be reviewed and approved by the State prior to printing, assembly, and/or distribution, as required in Contract Section A.23.h.	100%	100% 98.0-99.9% 96.0-97.9% Less than 96%	8 4 2 0	
15.	Distribution of Ongoing Member ID Cards/Welcome Packets	Ninety-five percent (95%) of welcome packets and ID cards shall be produced and mailed within ten (10) days of receipt of complete and accurate eligibility information, as required in Contract Section A.23.m(2).	95%	95% or greater 93.0-94.9% 91.0-92.9% Less than 91%	6 4 2 0	
16.	Claims Data Quality	As assessed by the State's DSS contractor, the Contractor's data submission to the DSS contractor shall meet the following measures as required in Contract Section A.19.f. Date of birth: Data missing for ≤ 3% of claims Pharmacy provider ID missing: Data missing for ≤ 1.5% of claims NDC or NDC 11 missing: Data missing for ≤ 1.5% of claims	3 measures met	3 measures met 2 measures met 1 measure met 0 measures met	4 2 1 0	
	Total Quarterly Score					
	Calculated Performance Payment					

Quarterly Score	At Risk Performance Payment
>=96	0% of previous quarter Administrative Fees
91 - 95	.25% of previous quarter Administrative Fees
86 - 90	.50% of previous quarter Administrative Fees
81 - 85	.75% of previous quarter Administrative Fees
76 - 80	1% of previous quarter Administrative Fees
71 - 75	1.5% of previous quarter Administrative Fees
66 - 70	2% of previous quarter Administrative Fees
61 - 65	3% of previous quarter Administrative Fees
<61	4% of previous quarter Administrative Fees

HIPAA BUSINESS ASSOCIATE AGREEMENT
COMPLIANCE WITH PRIVACY AND SECURITY RULES

THIS BUSINESS ASSOCIATE AGREEMENT (hereinafter "Agreement") is between **The State of Tennessee, Finance and Administration, Division of Benefits Administration** (hereinafter "Covered Entity") and _____ (hereinafter "Business Associate"). Covered Entity and Business Associate may be referred to herein individually as "Party" or collectively as "Parties."

BACKGROUND

Parties acknowledge that they are subject to the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act), in certain aspects of its operations.

Business Associate provides services to Covered Entity pursuant to one or more contractual relationships detailed below and hereinafter referred to as "Service Contracts."

LIST OF AGREEMENTS AFFECTED BY THIS BUSINESS ASSOCIATE AGREEMENT:

Contract Name:	**Execution Date:**
_____	_____

In the course of executing Service Contracts, Business Associate may come into contact with, use, or disclose Protected Health Information ("PHI"). Said Service Contract(s) are hereby incorporated by reference and shall be taken and considered as a part of this document the same as if fully set out herein.

In accordance with the federal privacy and security regulations set forth at 45 C.F.R. Part 160 and Part 164, Subparts A, C, D and E, which require Covered Entity to have a written memorandum with each of its Business Associates, the Parties wish to establish satisfactory assurances that Business Associate will appropriately safeguard PHI and, therefore, make this Agreement.

DEFINITIONS

Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 CFR §§ 160.103, 164.103, 164.304, 164.402, 164.501, and 164.504.

1.1 "Breach of the Security of the [Business Associate's Information] System" shall have the meaning set out in its definition at T.C.A. § 47-18-2107

1.2 "Business Associate" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.3 "Covered Entity" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.4 "Designated Record Set" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.5 “Electronic Protected Health Information” shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.6 “Genetic Information” shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.7 “Health Care Operations” shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.8 “Individual” shall have the same meaning as the term “individual” in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

1.9 “Information Holder” shall have the meaning set out in its definition at T.C.A. § 47-18-2107

1.10 “Marketing” shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.11 “Personal information” shall have the meaning set out in its definition at T.C.A. § 47-18-2107

1.12 “Privacy Official” shall have the meaning as set out in its definition at 45 C.F.R. § 164.530(a)(1).

1.13 “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, subparts A, and E.

1.14 “Protected Health Information” shall have the same meaning as the term “protected health information” in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

1.15 “Required by Law” shall have the meaning set forth in 45 CFR § 164.512.

1.16 “Security Incident” shall have the meaning set out in its definition at 45 C.F.R. § 164.304.

1.17 “Security Rule” shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Parts 160 and 164, Subparts A and C.

2. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Privacy Rule)

2.1 Business Associate is authorized to use PHI for the purposes of carrying out its duties under the Services Contract. In the course of carrying out these duties, including but not limited to carrying out the Covered Entity’s duties under HIPAA, Business Associate shall fully comply with the requirements under the Privacy Rule applicable to "business associates," as that term is defined in the Privacy Rule and not use or further disclose PHI other than as permitted or required by this Agreement, the Service Contracts, or as Required By Law. Business Associate is subject to requirements of the Privacy Rule as required by Public Law 111-5, Section 13404 [designated as 42 U.S.C. 17934] In case of any conflict between this Agreement and the Service Contracts, this Agreement shall govern.

2.2 The Health Information Technology for Economic and Clinical Health Act (HITECH) was adopted as part of the American Recovery and Reinvestment Act of 2009. HITECH and its implementing regulations impose new requirements on Business Associates with respect to privacy, security, and breach notification. Business Associate hereby acknowledges and agrees that to the extent it is functioning as a Business Associate of Covered Entity, Business Associate shall comply with HITECH. Business Associate and the Covered Entity further agree that the provisions of HIPAA and HITECH that apply to business associates and that are required to be incorporated by reference in a business associate agreement have been incorporated into this Agreement between Business Associate and Covered Entity. Should any provision not be set forth specifically, it is as if set forth in this Agreement in its entirety and is effective as of the Applicable Effective Date, and as amended.

2.3 Business Associate shall use appropriate administrative, physical, and technical safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement, Services Contract(s), or as Required By Law. This includes the implementation of Administrative, Physical, and Technical Safeguards to reasonably and appropriately protect the Covered Entity's PHI against any reasonably anticipated threats or hazards, utilizing the technology commercially available to the Business Associate. The Business Associate shall maintain appropriate documentation of its compliance with the Privacy Rule, including, but not limited to, its policies, procedures, records of training and sanctions of members of its Workforce.

2.4 Business Associate shall require any agent, including a subcontractor, to whom it provides PHI received from, maintained, created or received by Business Associate on behalf of Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI or other confidential information, to agree, by written contract with Business Associate, in accordance with 164.502(e)(1)(ii), ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of business associate agree to the same restrictions and conditions that apply to the business associate with respect to such information.

2.5 Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

2.6 Business Associate shall require its employees, agents, and subcontractors to promptly (up to 48 hours) report, to Business Associate, immediately upon becoming aware of any use or disclosure of PHI in violation of this Agreement. Business Associate shall report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement. Business Associate will also provide additional information reasonably requested by the Covered Entity related to the breach.

2.7 As required by the Breach Notification Rule, Business Associate shall, and shall require its subcontractor(s) to, maintain systems to monitor and detect a Breach of Unsecured PHI, whether in paper or electronic form.

2.7.1 Business Associate shall provide to Covered Entity notice of a Potential or Actual Breach of Unsecured PHI immediately upon becoming aware of the Breach.

2.7.2 Business Associate shall cooperate with Covered Entity in timely providing the appropriate and necessary information to Covered Entity.

2.7.3 Covered Entity shall make the final determination whether the Breach requires notification and whether the notification shall be made by Covered Entity or Business Associate.

2.8 If Business Associate receives PHI from Covered Entity in a Designated Record Set, Business Associate shall provide access, at the request of Covered Entity, to PHI in a Designated Record Set to Covered Entity, in order to meet the requirements under 45 CFR § 164.524, provided that Business Associate shall have at least 30 Business Days from Covered Entity notice to provide access to, or deliver such information.

2.9 If Business Associate receives PHI from Covered Entity in a Designated Record Set, then Business Associate shall make any amendments to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to the 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity, provided that Business Associate shall have at least t 30 Business Days from Covered Entity notice to make an amendment.

2.10 Business Associate shall make its internal practices, books, and records including policies and procedures and PHI, relating to the use and disclosure of PHI received from, created by or received by Business Associate on behalf of, Covered Entity available to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the Secretary, for purposes of determining Covered Entity's or Business Associate's compliance with the Privacy Rule.

2.11 Business Associate shall document disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosure of PHI in accordance with 45 CFR § 164.528.

2.12 Business Associate shall provide Covered Entity or an Individual, in time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an Individual for and accounting of disclosures of PHI in accordance with 45 CFR § 164.528, provided that Business Associate shall have at least 30 Business Days from Covered Entity notice to provide access to, or deliver such information which shall include, at minimum, (a) date of the disclosure; (b) name of the third party to whom the PHI was disclosed and, if known, the address of the third party; (c) brief description of the disclosed information; and (d) brief explanation of the purpose and basis for such disclosure. Business Associate shall provide an accounting of disclosures directly to an individual when required by section 13405(c) of Public Law 111-5 [designated as 42 U.S.C. 17935(c)].

2.13 Business Associate agrees it must limit any use, disclosure, or request for use or disclosure of PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request in accordance with the requirements of the Privacy Rule.

2.13.1 Business Associate represents to Covered Entity that all its uses and disclosures of, or requests for, PHI shall be the minimum necessary in accordance with the Privacy Rule requirements.

2.13.2 Covered Entity may, pursuant to the Privacy Rule, reasonably rely on any requested disclosure as the minimum necessary for the stated purpose when the information is requested by Business Associate.

2.13.3 Business Associate acknowledges that if Business Associate is also a covered entity, as defined by the Privacy Rule, Business Associate is required, independent of Business Associate's obligations under this Memorandum, to comply with the Privacy Rule's minimum necessary requirements when making any request for PHI from Covered Entity.

2.14 Business Associate shall adequately and properly maintain all PHI received from, or created or received on behalf of, Covered Entity

2.15 If Business Associate receives a request from an Individual for a copy of the individual's PHI, and the PHI is in the sole possession of the Business Associate, Business Associate will provide the requested copies to the individual and notify the Covered Entity of such action. If Business Associate receives a request for PHI in the possession of the Covered Entity, or receives a request to exercise other individual rights as set forth in the Privacy Rule, Business Associate shall notify Covered Entity of such request and forward the request to Covered Entity. Business Associate shall then assist Covered Entity in responding to the request.

2.16 Business Associate shall fully cooperate in good faith with and to assist Covered Entity in complying with the requirements of the Privacy Rule.

3 OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Security Rule)

3.1 Business Associate shall fully comply with the requirements under the Security Rule applicable to "business associates," as that term is defined in the Security Rule. In case of any conflict between this Agreement and Service Agreements, this Agreement shall govern.

3.2 Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the covered entity as required by the Security Rule and Public Law 111-5. This includes specifically, but is not limited to, the utilization of technology

commercially available at the time to the Business Associate to protect the Covered Entity's PHI against any reasonably anticipated threats or hazards. The Business Associate understands that it has an affirmative duty to perform a regular review or assessment of security risks, conduct active risk management and supply best efforts to assure that only authorized persons and devices access its computing systems and information storage, and that only authorized transactions are allowed. The Business Associate will maintain appropriate documentation to certify its compliance with the Security Rule.

3.3 Business Associate shall ensure that any agent, including a subcontractor, to whom it provides electronic PHI received from or created for Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI supplied by Covered Entity, to agree, by written contract (or the appropriate equivalent if the agent is a government entity) with Business Associate, in accordance with 164.502(e)(1)(ii), ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of business associate agree to the same restrictions and conditions that apply to the business associate with respect to such information.

3.4 Business Associate shall require its employees, agents, and subcontractors to report to Business Associate within five (5) Business Days, any Security Incident (as that term is defined in 45 CFR § 164.304) of which it becomes aware. 45 CFR 164.314(a)(2)(C) requires that business associate shall report to the covered entity any security incident of which is becomes aware, including breaches of unsecured protected health information as required by 164.410. Business Associate shall promptly (up to 48 hours) report any Security Incident of which it becomes aware to Covered Entity. Provided however, that such reports are not required for attempted, unsuccessful Security Incidents, including trivial and routine incidents such as port scans, attempts to log-in with an invalid password or user name, denial of service attacks that do not result in a server being taken off-line, malware, and pings or other similar types of events.

3.5 Business Associate shall make its internal practices, books, and records including policies and procedures relating to the security of electronic PHI received from, created by or received by Business Associate on behalf of, Covered Entity available to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the Secretary, for purposes of determining Covered Entity's or Business Associate's compliance with the Security Rule.

3.6 Business Associate shall fully cooperate in good faith with and to assist Covered Entity in complying with the requirements of the Security Rule.

3.7 Notification for the purposes of Sections 2.8 and 3.4 shall be in writing made by email/fax, certified mail or overnight parcel immediately upon becoming aware of the event, with supplemental notification by facsimile and/or telephone as soon as practicable, to:

State of Tennessee
Benefits Administration
Attn: Chanda Rainey
HIPAA Privacy & Security Officer
312 Rosa L. Parks Avenue
1900 W.R.S. Tennessee Towers
Nashville, TN 37243-1102
Phone: (615) 770-6949
Facsimile: (615) 253-8556

With a copy to:

State of Tennessee
Benefits Administration
Contracting and Procurement Manager
312 Rosa L. Parks Avenue
1900 W.R.S. Tennessee Towers
Nashville, TN 37243-1102

Phone: (615) 532-4598
Facsimile: (615) 253-8556

3.8 Business Associate identifies the following key contact persons for all matters relating to this Agreement:

_____
_____
_____
_____
_____
_____
_____
_____

Business Associate shall notify Covered Entity of any change in the key contact during the term of this Agreement in writing within ten (10) Business Days.

4. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

4.1 Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in Service Contract(s), provided that such use or disclosure would not violate the Privacy and Security Rule, if done by Covered Entity. Business Associate's disclosure of PHI shall be subject to the limited data set and minimum necessary requirements of Section 13405(b) of Public Law 111-5, [designated as 42 U.S.C. 13735(b)]

4.2 Except as otherwise limited in this Agreement, Business Associate may use PHI as required for Business Associate's proper management and administration or to carry out the legal responsibilities of the Business Associate.

4.3 Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or provided that, if Business Associate discloses any PHI to a third party for such a purpose, Business Associate shall enter into a written agreement with such third party requiring the third party to: (a) maintain the confidentiality, integrity, and availability of PHI and not to use or further disclose such information except as Required By Law or for the purpose for which it was disclosed, and (b) notify Business Associate of any instances in which it becomes aware in which the confidentiality, integrity, and/or availability of the PHI is breached immediately upon becoming aware.

4.4 Except as otherwise limited in this Agreement, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 45 CFR § 164.504(e)(2)(i)(B).

4.5 Business Associate may use PHI to report violations of law to appropriate Federal and State Authorities consistent with 45 CFR 164.502(j)(1).

4.6 Business Associate shall not use or disclose PHI that is Genetic Information for underwriting purposes. Moreover, the sale, marketing or the sharing for commercial use or any purpose construed by Covered Entity as the sale, marketing or commercial use of member's personal or financial information with affiliates, even if such sharing would be permitted by federal or state laws, is prohibited.

4.7 Business Associate shall enter into written agreements that are substantially similar to this Business Associate Agreement with any subcontractor or agent which Business Associate provides access to Protected Health Information.

4.8 Business Associates shall implement and maintain information security policies that comply with the HIPAA Security Rule.

5. OBLIGATIONS OF COVERED ENTITY

5.1 Covered Entity shall provide Business Associate with the Notice of Privacy Practices that Covered Entity produces in accordance with 45 CFR § 164.520, as well as any changes to such notice. Covered Entity shall notify Business Associate of any limitations in its notice that affect Business Associate's use or disclosure of PHI.

5.2 Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses.

5.3 Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use of PHI.

6. PERMISSIBLE REQUESTS BY COVERED ENTITY

6.1 Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy or Security Rule, if done by Covered Entity.

7. TERM AND TERMINATION

7.1 Term. This Agreement shall be effective as of the date on which it is signed by both parties and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, Section 7.3. below shall apply.

7.2 Termination for Cause.

7.2.1. This Agreement authorizes and Business Associate acknowledges and agrees Covered Entity shall have the right to immediately terminate this Agreement and Service Contracts in the event Business Associate fails to comply with, or violates a material provision of, requirements of the Privacy and/or Security Rule or this Memorandum.

7.2.2. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

7.2.2.1. Provide a reasonable opportunity for Business Associate to cure the breach or end the violation, or

7.2.2.2. If Business Associate has breached a material term of this Agreement and cure is not possible or if Business Associate does not cure a curable breach or end the violation within a reasonable time as specified by, and at the sole discretion of, Covered Entity, Covered Entity may immediately terminate this Agreement and the Service Agreement.

7.2.2.3. If neither cure nor termination is feasible, Covered Entity shall report the violation to the Secretary of the United States Department of Health in Human Services or the Secretary's designee.

7.3 Effect of Termination.

7.3.1. Except as provided in Section 7.3.2. below, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of, Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

7.3.2. In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction unfeasible. Upon mutual agreement of the Parties that return or destruction of PHI is unfeasible, Business Associate shall extend the protections of this Memorandum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction unfeasible, for so long as Business Associate maintains such PHI.

8. MISCELLANEOUS

8.1 Regulatory Reference. A reference in this Agreement to a section in the Privacy and or Security Rule means the section as in effect or as amended.

8.2 Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Rules and the Health Insurance Portability and Accountability Act, Public Law 104-191, including any amendments required by the United States Department of Health and Human Services to implement the Health Information Technology for Economic and Clinical Health and related regulations upon the effective date of such amendment, regardless of whether this Agreement has been formally amended, including, but not limited to changes required by the American Recovery and Reinvestment Act of 2009, Public Law 111-5.

8.3 Survival. The respective rights and obligations of Business Associate under Section 7.3. of this Memorandum shall survive the termination of this Agreement.

8.4 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity and the Business Associate to comply with the Privacy and Security Rules.

8.5 Notices and Communications. All instructions, notices, consents, demands, or other communications required or contemplated by this Agreement shall be in writing and shall be delivered by hand, by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below, or to such other party, facsimile number, or address as may be hereafter specified by written notice.

COVERED ENTITY:
State of Tennessee
Department of Finance and Administration
Benefits Administration
ATTN: Chanda Rainey
HIPAA Privacy & Security Officer
312 Rosa L. Parks Avenue
1900 W.R.S. Tennessee Towers
Nashville, TN 37243-1102
Phone: (615) 770-6949
Facsimile: (615) 253-8556
E-Mail: benefits.privacy@tn.gov

BUSINESS ASSOCIATE:

With a copy to:
ATTN: Seannalyn Brandmeir
Procurements & Contracting Manager
At the address listed above
Phone: (615) 532-4598
Facsimile: (615) 253-8556
E-Mail: seannalyn.brandmeir@tn.gov

All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the date of hand delivery; as of the date specified for overnight courier service delivery; as of three (3) Business Days after the date of mailing; or on the day the facsimile transmission is received mechanically by the facsimile machine at the receiving location and receipt is verbally confirmed by the sender.

8.6 Strict Compliance. No failure by any Party to insist upon strict compliance with any term or provision of this Agreement, to exercise any option, to enforce any right, or to seek any remedy upon any default of any other Party shall affect, or constitute a waiver of, any Party's right to insist upon such strict compliance, exercise that option, enforce that right, or seek that remedy with respect to that default or any prior, contemporaneous, or subsequent default. No custom or practice of the Parties at variance with any provision of this Agreement shall affect, or constitute a waiver of, any Party's right to demand strict compliance with all provisions of this Agreement

8.7 Severability. With respect to any provision of this Agreement finally determined by a court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the Parties shall abide by such court's determination. In the event that any provision of this Agreement cannot be reformed, such provision shall be deemed to be severed from this Agreement, but every other provision of this Agreement shall remain in full force and effect.

8.8 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee except to the extent that Tennessee law has been pre-empted by HIPAA.

8.9 Compensation. There shall be **no** remuneration for performance under this Agreement except as specifically provided by, in, and through, existing administrative requirements of Tennessee State government and services contracts referenced herein.

8.10 Security Breach A violation of HIPAA or the Privacy or Security Rules constitutes a breach of this Business Associate Agreement and a breach of the Service Contract(s) listed on page one of this agreement, and shall be subject to all available remedies for such breach.

IN WITNESS WHEREOF,

Date:

Larry B. Martin, Commissioner of Finance & Administration **Date:**